



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Connecticut**

**Application for 2008
Annual Report for 2006**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The assurances and certifications are on file at the Connecticut Department of Public Health and are available from:

Joseph Teal
Director, Office of Affirmative Action
Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Historically, attendance at the MCHBG public hearings has been minimal, even with statewide advertising. This year, in an effort to increase public input into the MCHBG application, the CT Department of Public Health (DPH) decided to conduct focus groups in Hartford and Danbury for families and community members to give input regarding MCH programs. In addition to completing a survey, participants were given an overview of the MCHBG, programs funded and the opportunity to dialog with DPH staff about programs and services. During this session, two additional families were recruited to serve as family readers of the MCHBG application and two families/consumers requested to participate on the DPH's Adolescent Strategic Plan Workgroup and the MCH Infoline Advisory Committee. The focus group report can be found as a supporting document, "MCH Focus Groups 2007."

Requests for written testimony were posted on the DPH website and contractors were notified of the website posting. To date, no written testimony has been received.

During the spring of 2006 families of children and youth with special health care needs were identified and 2 additional families were select to review and comment on this year's block grant application. This report can be found as a supporting document, "Block Grant Readers 2007."

Public and consumer input remains a strong priority for the CT DPH and we will continue to solicit continuous input to our programs and services by assuring family/consumer participation on the Medical Home Advisory Council, the Perinatal Depression Screening Workgroup, the Adolescent Health Workgroup and the MCH Infoline Advisory Committee.

An attachment is included in this section.

An attachment is included in this section.

II. Needs Assessment

In application year 2008, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

III. State Overview

A. Overview

Connecticut is a relatively small state of about 5,000 square miles and 3.5 million persons. Nearly one million of Connecticut residents are between the ages of birth to 19, amounting to 27% of the state's population (1). It is clear that the population in Connecticut has become more diverse during the past decade. The Hispanic, Asian, and African American/Black population increased an estimated 50, 68, and 13 percent respectively since the 1990 census, while the white population decreased 4 percent. The white non-Hispanic population comprised 83.8 percent of the Connecticut population in 1990, but that percentage dropped to 77.5 in 2000 and has remained level since then (2). See Table 1 in the document attached to this section.

/2007/ The estimated population in CT as of July 1, 2004 grew by over 94,000 to

3,503,604.//2007//

/2008/ The estimated population in CT as of July 1, 2005 increased slightly by 6,693 to 3,510,207.//2008//

I. Maternal and Child Health Indicators

A. Maternal and Child Demographics

With Census 2000 information released, a more detailed picture of Connecticut and the United States became available. As the Census Bureau releases Supplemental Population Estimates, comparisons can be made on residents of Connecticut and the United States. See Tables 2 and 3 in the document attached to this section. Residents of the major cities (Bridgeport, Hartford, and New Haven) tend to be younger, unmarried, poorer, less educated, more likely to be unemployed, on public assistance, and be Hispanic or African American/Black than the state as a whole. These comparisons are in stark contrast to the demographics of some wealthy suburbs such as Darien and New Canaan.

Many indicators of maternal and child health within Connecticut compare favorably with the United States as a whole, however, there are high risk groups which experience a greater share of the burden of adverse health risks and outcomes. In Connecticut in 2002, an African American/Black baby was two and a half times more likely to die within its first year of life than a white baby, twice as likely to have late or no prenatal care, and almost twice as likely to be born with low birthweight. See Table 4 in the document attached to this section. These disparities are documented in more detail in the Needs Assessment that was completed as part of the 2006 MCHBG Application. Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community.

B. Infant Mortality

The overall infant mortality rate has declined in the United States and Connecticut during the past two decades (3). However, African American/Black babies consistently have had higher infant mortality rates than White and Hispanic populations in Connecticut and in the U.S. From 1981 to 2003, Connecticut's infant death rate fell from 12.0 to 5.3 deaths per 1,000 live births. However, the infant mortality rates for African Americans/Blacks in 2003 was 11.5 and substantially exceeded the rates for whites in all years from 1981 to 2003. See Figure 1 in the document attached to this section.

This gap reflects the consistently higher prevalence among the non-white population for risk factors, such as birth rates among teenage women, lack of adequate prenatal care, and low birthweight. Targeting prevention programs to groups showing a high rate of low and very low birthweight infants (such as women in the urban centers or the state's African American/Black population) may produce the greatest effect on reducing the overall risk factors among the nonwhite infant population in the state.

Programming within the Department of Public Health (DPH) to reduce infant mortality is aimed at the period before conception, along with the prenatal and postnatal periods. Pre-conception interventions aimed at school-aged audiences and women of childbearing age include primary care services, targeted health education programs, and outreach and case-finding to link individuals and families to primary and preventive services. Prenatal efforts are focused on getting mothers into regular care early in the pregnancy and keeping both regular and specialty care appointments as directed by their health care provider. Postnatal efforts include medical testing for genetic disorders and maintaining good health for healthy infants and their mothers. ***//2008/ Infant mortality rates (IMR) continue to be higher in the African American and Hispanic population. For 2005, the provisional IMR for African Americans was 10.7 per 1,000 live births compared to 3.4 per 1,000 live births for Whites..//2008//***

C. Births to Teens

Teen birth rates declined dramatically during the past decade as the birth rate for teens age 15-19 dropped from 59.0 to 43.0 per 1,000 teens nationally between 1993 and 2003. In Connecticut, the rate dropped from 38.8 to 25.8 infants born per 1,000 female teens (4). An African American/Black or Hispanic baby born in CT in 2003 was approximately 4 to 5 times more likely to have a teenager as a mother than a white baby. See Figure 1 in attachment to this section.

According to the National Center for Health Statistics preliminary birth data for 2003, Connecticut ranked fifth in the nation for its teen pregnancy rate for 15-19 year olds, with a rate of 25.8 births per 1,000 females ages 15-19 in comparison to the national rate of 43.0 (4). The percent of births to teens varies by race and ethnicity. The overall percent of births to teens has dropped in the last decade, especially among African Americans/Blacks. However, there remains a greater percentage of pregnancies among teens in the African American/Black and Hispanic populations when compared to white teens. See Figure 2 in the document attached to this section.

Teen pregnancy is considered a public health problem for several reasons related to the health of both the mother and newborn. Early sexual activity can result in a higher risk for sexually transmitted diseases, which could harm the fetus and impair the future fertility and health of the mother. Preventive interventions to address teen pregnancy through Connecticut's Title V programs include programs to delay the onset of sexual activity, promote abstinence as the social norm, reduce the number of adolescents who have sex at young ages, and increase the number of sexually active adolescents who use contraceptives effectively. State-sponsored specialized programs such as the Right from the Start Program serve pregnant and parenting teens. This program provides intensive case management services with emphasis on promoting positive pregnancy outcomes, positive parenting and breastfeeding.

//2008/ The provisional teen birth rate for 2005 was 23.3 per 1,000 teens age 15-19 years old, with the largest proportion being births to Hispanic teens (77.1) followed by African American teens (41.6). DPH is making programmatic changes to more accurately reflect the data regarding births to teens. //2008//

D. Prenatal Care

Non-adequate prenatal care is a composite measure, reflecting both the time of the first prenatal visit and the number of visits. The "non-adequate" grouping includes both "inadequate" and "intermediate" care as defined in the Kessner Index of prenatal care (5). Adequacy of prenatal care has improved during the past decade. Although the gap is closing in differences in race, adequate prenatal care is less often achieved by African American/Black and Hispanic women. See Figure 3 in the document attached to this section. In 2002, 2.0 percent of CT women received late or no prenatal care in comparison to 3.6 percent nationally. Connecticut ranked one of the lowest rates of late or no prenatal care, along with the other New England states (6).

The Department has tried to improve access to prenatal care through several strategies, such as

supporting sites for primary care and free pregnancy testing at family planning clinics. At these sites, patients are appropriately referred for early prenatal care, in keeping with established protocols.

//2008/ In 2005, the provisional percent of non-adequate prenatal care in CT was 19.8%. Non-Hispanic African American women were 1.8 times more likely to receive non-adequate prenatal care than non-Hispanic White women (28.9% among non-Hispanic African American women versus 16% among non-Hispanic White women). Hispanic women were 1.7 time more likely to receive non-adequate prenatal care (27.3%).//2008//

E. Low Birthweight

Low birthweight (under 2,500 grams) is a major cause of infant mortality and long-term health problems. The impact of low birthweight on infant mortality occurs primarily during the first 28 days of life (the neonatal period), when low birthweight infants are about 40 times more likely than normal weight infants to die. For very low birthweight infants (less than 1,500 grams or 3 lbs. 3 oz), the risk of death is 200 times higher than among normal-weight newborns. See Figure 4 in the document attached to this section. In 2003, 7.5 percent of births had low birthweight in Connecticut in comparison to 7.9 percent nationally (4). While there have been improvements in the infant mortality rates, low birthweight has remained relatively stable for the past two decades. Low birthweight is more common among infants of African American/Black and Hispanic mothers. Likewise, twins and multiple births have a higher frequency of low and very low birthweights compared with singleton newborns.

//2008/ In 2005, the provisional low birth weight percent in CT was 8.0%. Low birth weight remains highest among the African American mothers at 13.7% while Hispanic mothers have a percent close to the CT percent (8.3%).//2008//

F. Other MCH Indicators

The positive maternal and infant health effects of breastfeeding have been well documented. The estimated rate of breastfeeding in Connecticut has improved from 68.7% to 69.3%, just shy of the state's goal (69.5%). Generally, the rate of women in Connecticut breastfeeding while in the hospital is 73.2% and at 6 months the rate is 28.3% (7). Thus, the rate of initiation of breastfeeding among all women has improved (as indicated by hospital rates) but declines rapidly by six months. The role of the Title V program has been to promote breastfeeding as a social norm in the state. Other infrastructure building activities included conducting a statewide needs assessment of the breastfeeding practices of Black and African American women to determine how best to promote and support breastfeeding in this population, which breastfeeds at a lower rate than other groups.

Although pregnant women in CT were less likely to smoke than their counterparts nationwide (see the CT Needs Assessment), smoking during pregnancy remains a public health issue. The role of the Title V program is multi-fold and includes functioning as a partner with the DPH's Tobacco Control Program to address smoking cessation during pregnancy, as well as with federal and regional level initiatives (i.e. -- National Partnership to Help Pregnant Smokers Quit), which can be implemented at the state level. Other infrastructure building activities including the facilitation of meetings with the state DSS and Managed Care Organizations (MCOs) to discuss reimbursement mechanisms for smoking cessation products and support services.

//2008/ The DPH continues to address the need for perinatal depression screening and has instituted a pilot, consultative line for providers who screen clients for perinatal depression.//2008//

II. Other Indicators

A. Socioeconomic Indicators in Connecticut

In Connecticut, there is a disparity between the wealthiest and poorest citizens. While Connecticut is one of the wealthiest states in the country, several cities have high rates of

poverty. With a median household income of \$55,004, Connecticut was ranked fifth in the nation (8) in 2003. Within Connecticut, however, the median family income and other characteristics recorded in the 2000 Census vary within the State and its large cities, and New York suburbs. While many children within Connecticut lived in affluent homes, nearly 86,000 lived below the poverty level (9). In Hartford, over 40% of the children were estimated to be living in poverty (10), a figure surpassed only by one other city in the nation with a population over 100,000. Despite its relative wealth, and with recent decreases in state revenues, efficiency is paramount to reversing child health disparities within the state. The economic disparity experienced by the cities is mirrored in differing maternal and child health statistics. See Table 5 in the document attached to this section.

The economic recession that began mid year 2000 appears to have ended, recovering from a downturn in the economy since the terrorist attacks of September 11, 2001. Between September 2003 and March 2005, Connecticut recovered 28,000 of the 61,000 jobs lost since 2000 (11). The state's economy is supported predominantly by services, manufacturing, and retail trade industries. Unemployment in Connecticut has risen to 5.3 percent in comparison to 5.1 percent nationally (12).

//2008/ CT's labor force is expected to grow by 8,000 workers from 2006 to 2007, with unemployment falling to 4.4 percent compared to 4.5 percent nationally.//2008//

B. Health Care Delivery Environment in Connecticut

Connecticut does not function on a county-based system for the delivery of public health services to its residents. Direct health care services are delivered to residents through a wide range of providers including, but not limited to, school based health centers, community health centers, outpatient clinics, physicians offices for primary care services; free-standing and hospital-based outpatient surgical centers for diagnostic or minor surgical procedures; acute care hospitals for emergency care, routine outpatient or inpatient services; long term care facilities for chronic care or rehabilitative service; and increasingly non-institutional settings, such as the home, for services ranging from intravenous infusion of medications to physical therapy. The licensure or certification of health care facilities and health care professionals guides promotion of high quality health care and services. Utilization of services is dependent upon a variety of demographic, economic, social and environmental factors, all of which are considered when planning the delivery of Title V programs, services and activities.

Perinatal Care in CT is provided through a network of Healthy Start Providers. The Healthy Start Program is a collaboration between the State Departments of Social Services (DSS) and Public Health. The goal of the state Healthy Start Program is to promote positive birth outcomes and maternal and infant health among at-risk, low income families in CT. The DSS contracts with 5 agencies statewide, which in turn contract with other community based providers to provide case management services to pregnant women and their children up to age three. To complement the Healthy Start program, CT also has a Nurturing Families Network, which operates in all twenty-nine birthing hospitals in the state. It provides parent education and support for first time parents. Unlike the Healthy Start program, families are enrolled in the Nurturing Families Network when they are expecting or have just given birth to their first child.

Connecticut is part of the national trend in the delivery of health care services in which managed care has expanded and has become the dominant financing mechanism. The Connecticut care delivery system is challenged by managed care and the lack of sufficient services for the uninsured. These methods of financing affect not only the availability and delivery of services, but also the quality of patient outcomes. Hospital mergers have occurred in Connecticut and lengths of stays in hospitals have decreased, as has the rate of hospitalizations (13).

//2008/ Seven " Minute Clinics" have been established at local CVS pharmacies. These clinics are staffed with licensed Nurse Practitioners and Physician Assistants & serve clients ages 18 months of age and older.

C. Safety Net Providers

Safety Net Providers comprise the system of care that addresses the needs of those individuals who experience barriers when accessing the traditional health care system. Some of these barriers include financial, transportation, cultural, linguistic, etc. One of the primary groups targeted by safety net providers are the uninsured. In Connecticut, the safety net provider system is comprised of Community Health Centers, School Based Health Centers, Visiting Nurse Associations, Local Health Department and Family Planning Clinics. Maintaining and supporting the safety net providers is a priority for the State. With increasing financial challenges, CT's focus is to avoid the erosion of this health care delivery system. During the 2005 legislative session, the Torrington Community Health Center, an FQHC look-alike, was allocated state funding and the remaining CHCs were given a small cost of living adjustment. /2007/ During the 2006 legislative session the community health centers received Cost of Living Adjustments (COLAs) on state funding. //2007//

/2008/ United Community and Family Services, Inc. in Norwich was given \$200,000 to provide community health center services in addition to the oral health services already funded. The CHCs & SBHCs received COLAs on state funding. State bonding dollars have been made available to CHCs & SBHCs continue to build their capacity as safety net providers. During the past year there has been a merger between New Britain General Hospital and Bradley Memorial Hospital. Both are now under the auspices of The Hospital of Central Connecticut. //2008//

D. Health Insurance

HUSKY (Healthcare for Uninsured Kids and Youth) is Connecticut's health insurance plan for children and families. In 1997 when the federal government created the State Children's Health Insurance Program, Connecticut renamed part of its Medicaid program that serves children and low-income families "HUSKY A" and established the "HUSKY B" program for uninsured children with family income that exceeds the HUSKY A limits. Both HUSKY A and B are managed care programs, administered through the Department of Social Services and private health plans. HUSKY A covers pregnant women and children in families with income under 185% of the federal poverty level. HUSKY A provides preventive pediatric care for all medically necessary services. It also covers parents and relative caregivers in families with income under 100% of federal poverty. There are 310,878 persons, including 218,420 children under 19 in HUSKY A as of May, 2005. The basic HUSKY package includes preventive care, outpatient physician visits, prescription medicines, inpatient hospital and physician services, outpatient surgical facility services, mental health and substance abuse services, short-term rehabilitation and physical therapy, skilled nursing facility care, home health care and hospice care, diagnostic x-ray and laboratory tests, emergency care, durable medical equipment, eye care and hearing exams, and dental care (14).

/2007/ As of July 1, 2005, the FPL for HUSKY A coverage was increased from 100% to 150%. There are 299,052 persons, including 211,991 children under 19 in HUSKY A as of June 2006. //2007//

/2008/ As of July 1, 2006 the FPL for HUSKY A coverage for parents and caretaker relatives was increased from 100% to 150%. There are 298,145 persons, including 207,323 children less than 19 years of age in HUKSY as of May 2007. //2008//

HUSKY B provides health care for children without employer-sponsored coverage for a sliding fee. There are 15,640 children under 19 in HUSKY B as of May 2005 (15). As part of HUSKY B, HUSKY Plus provides supplemental benefits for Children and Youth with Special Health Care Needs enrolled in HUSKY B. Services include Multidisciplinary teams (Pediatricians, Advanced Practice Nurses, Benefits Specialists, Family Resource Coordinators and Advocates) who work with families to identify their child's care needs and the resources to meet those needs.

Community-based mental health and substance abuse services to children and youth with intensive behavioral health needs are also offered under HUSKY Plus.

/2007/ HUSKY B enrollment increased slightly to 17,181 as of May, 2007. As of January 1, 2006, behavioral services were carved out and are under the CT Behavioral Health Partnership.

Key elements of the BHP includes: (1) Administrative integration (one manager for all clinical services, one payer for all services except residential and one stop customer services), (2) Joint DCF/DSS contract and (3) DCF/DSS Memorandum of Understanding. Populations served by the BHP includes HUSKY A, HUSKY B and Limited Benefit Program (DCF only).//2007//

/2008/ HUSKY B enrollment increased slightly to 17,181 as of May 2007.//2008//

In a January 2005 review of 2003 HUSKY data, the Connecticut Voices for Children found that just over half of the children covered by HUSKY received well-child care in 2003, with the utilization rates being the lowest among older adolescents (aged 16-19 years) (16). Utilization was lower for dental care, with only 47% of enrolled children having any dental care in 2003. While there have been improvements in dental care utilization rates during the past few years, fewer than half of enrolled children who are eligible for preventive dental care services through HUSKY A actually received these services (17).

There have been changes that limit eligibility or enrollment. On July 1, 2005 families now only receive Transitional Family Assistance (TFA) for one year rather than two years. As of July 1, 2005 new and increased premiums will be imposed on children in HUSKY B. Also there is elimination of self-declaration of income mandating that applications received after July 1, 2005 show documentation of income. Fortunately there are changes that improve eligibility and enrollment, presumptive eligibility for HUSKY A children is being restored and now pregnant women experience expedited eligibility when enrolling in HUSKY A. Another improvement is that DSS is implementing increased income guidelines for parents and caretaker relatives with incomes between 100% and 150% of the federal poverty level effective July 1, 2005.

/2007/ In October 2005, the Legislature rescinded the increase in premiums. Only band 2 HUSKY B families continue to pay the \$30 for single child and \$50 for two or more children premium. Band 1 families do not have to pay a premium. Effective July 1, 2006, families are again allowed to self-declare unless the declared income is questionable.

As of July 1, 2006, new applicants will need to document their US citizenship. Those recipients already active prior to July 1, will have to document citizenship at the time of renewal.//2007//

/2008// Effective July 1, 2006, families are again allowed to self-declare unless the declared income is questionable for the applicants are self employed.//2008//

Connecticut Voices for Children released a report on Births to Mothers in HUSKY A (18). In 2002, there were 41,191 births to Connecticut residents, including 9,775 births (24%) to mothers enrolled in HUSKY A when their babies were born. Compared to other mothers who gave birth that year, mothers who were enrolled in HUSKY A were younger (average age 25, compared with 31 for other mothers) and far more likely to be teens (21% vs. 3% of other mothers). They were more likely to be Black non-Hispanic (25% v.7%) or Hispanic (32% vs. 12% of other births).

/2008// Compared to all other babies in CT, rates for low birth weight, preterm and teen births were higher for babies born to mothers covered by HUSKY A and fee for service

Medicaid. //2008//

Health insurance is an important component of access to health care. People without health insurance are less likely to receive the basic health care services that the insured receive. In some cities and towns, HUSKY A covered a far greater proportion of pregnancies. In these communities, the importance of HUSKY A for improving maternal health and birth outcomes cannot be overstated. The collaborative efforts of HUSKY, prenatal care providers, community-based organizations, and other Title V funded programs are essential for ensuring that women become pregnant when they chose to, begin pregnancy in good health, begin prenatal care early, and obtain risk-appropriate high quality prenatal care and social support services throughout pregnancy (18).

As the Title V agency in Connecticut, DPH has contributed policy guidance and technical assistance to the HUSKY program by:

- Enhancing enrollment in HUSKY by participating in the Covering Connecticut's Kids coalition, a network of organizations involved in HUSKY outreach (including DSS, Benova, and Infoline).
 - Partnering in the work to expand Katie Beckett waiver and other related DSS waiver applications that will support access to comprehensive care for children and youth.
 - Working with the State Medicaid Managed Care Council to promote outreach for prenatal access in first trimester and Medicaid reimbursement of care coordination services to improve access to pediatric primary health care access under Early Periodic Screening and diagnostic and Treatment Services.
 - Working with State Commission on Children, HUSKY and other Connecticut key stakeholders in promoting home visitation for mothers with newborns, particularly at risk mothers using Healthy Start and Nurturing Families Programs.
 - Working with Local Health Departments and Immigrant health to improve health status of the Connecticut residence.
 - Providing care coordination and respite care as well as family support services to children with special health care needs in HUSKY as a way of filling the gaps in care.
 - Developing linkages between HUSKY and state public health programs such as WIC, childhood immunizations, Medical Home Learning Collaborative of primary care physicians, School Based Health Centers (SBHC), Community Health Centers, Family support council, and other essential community providers and Title V funded programs, (including an MOU with DSS regarding these linkages).
 - Facilitating the process by which School Based Health Centers (SBHC) are named as the only essential community providers in the DSS waiver application, resulting in all SBHCs having contracts with all managed care plans for Husky A and B.
 - Supporting Community Health Centers/Connecticut Primary Care Association and SBHCs in their efforts to receive statewide outreach grants for Husky B.
- Utilizing existing services to create access points for referral or applications to enhance outreach and enrollment.
- Identifying and developing needed enabling services through work with other providers and local health departments; and
 - Implementing quality improvement activities and evaluation.

A growing concern is the national and state trend among the Hispanic population being disproportionately underinsured. Although Hispanics are 10 percent of Connecticut's total population, they constitute 40 percent of its uninsured. Hispanics are five and a half times more likely to be uninsured as persons from all other ethnic or racial groups. This result reflects a national phenomenon. Hispanics are significantly less likely than non-Hispanics to have health coverage, to have a regular health care provider, and to receive regular preventative care and screenings (19).

//2008/ It is estimated that 347,000- 407,000 adults in CT are uninsured.//2008//

E. Racial and Ethnic Disparities

Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community. When reviewing Connecticut's maternal and child health indicators, racial and ethnic disparities are quite evident. According to the "Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health Care" (20), a multi-level strategy must be employed to address the potential causes of racial/ethnic disparities. In CT some of the strategies have included: 1. Improving the number and capacity of providers in underserved communities by continuing to function as a liaison in the recruitment and retention of primary care health professionals. This particular activity is carried out by the Primary Care Office within the DPH and by working collaboratively with the CT Primary Care Association. 2. Increasing the knowledge base on causes and intervention to reduce disparities by collecting and analyzing data on health care practices and use across racial and ethnic groups. In a study of Latina adolescent women in CT who were pregnant, they all reported that their pregnancy was "accidental" and that if they thought they would have become pregnant they would have "delayed sexual activity" (21). The DPH is also in the process of finalizing a study on the breastfeeding practices of African American/Black women. CT's PRAMS-like study or the Pregnancy Risk Assessment Tracking Survey (PRATS) data is currently being weighted and should provide additional racial and ethnic specific MCH data. 3. The re-establishment of the DPH's Office of Multicultural Health in raising public and provider awareness of racial/ethnic disparities in health care. The Office is responsible for improving the health of all state residents by eliminating differences in disease, disability, and death rates among ethnic, racial and cultural populations. The office may provide grants for culturally appropriate health education demonstration projects and apply for, accept, and spend public and private funds for these projects. It also may recommend policies, procedures, activities and resource allocations to improve health among the state's racial, ethnic, and cultural populations.

The Connecticut Health Foundation (CHF) (<http://www.cthealth.org>) is the state's largest independent, non-profit grant-making foundation dedicated to improving the health of the people of Connecticut through systemic change and program innovation. After meeting with state agencies, community leaders, and health care professionals, the Foundation selected 3 program areas to focus its resources: Improving Access to Children's Mental Health Services; Reducing Racial and Ethnic Health Disparities; and Expanding Access to and Utilization of Oral Health Services.

The Foundation's Policy Panel on Racial and Ethnic Health Disparities released its final report in March, 2005 which includes state policy recommendations that begin to address health disparities. Those recommendations specific to the Department of Public Health include:

- The Connecticut Department of Public Health should collect and integrate racial and ethnic health data into all of its statewide planning efforts and publish a biennial report on key findings from data collected on the health status of racial and ethnic populations.
- The Connecticut Office of Health Care Access and the Connecticut Department of Public Health should require health care organizations, including providers and payers, to collect data on each patient's primary language in health records and information systems, and post signage in the languages of the patients they serve.
- The Connecticut Department of Public Health should establish a certification program for all medical interpreters to ensure cultural competence and quality service.
- The Health Systems Regulations Bureau of the Connecticut Department of Public Health should establish a system for monitoring and enforcing the law regarding linguistic access in acute care hospitals (Public Act No. 00-119) and publish a report on its findings for public and legislative review.
- The Connecticut Department of Public Health should (a) collect and track data on the race and ethnicity of all licensed medical professionals and issue an annual report on the diversity of the health care workforce in the state and (b) require all health care professionals to participate in cultural and linguistic competence continuing education programs through licensure

requirements.

- The State of Connecticut should allocate no less than \$2.12 million of Connecticut's State Tobacco Settlement funds to specifically support evidence-based, culturally and linguistically competent health promotion programs that respond to the health needs of underserved racial and ethnic populations.

- The Connecticut Department of Public Health should match all available federal dollars allocated to the national loan forgiveness program each year; target these funds to attract a greater number of historically underrepresented students to the health professions; and promote the loan forgiveness program broadly and effectively.

/2007/ In the spring of 2005, the Department of Public Health made a commitment to participate in the Meaningful Exchange national pilot program developed by the University of Tennessee through a grant from the Maternal and Child Bureau of the United States Department of Health and Human Services. The goal of Meaningful Exchange is to enhance individual cultural competence of program staff in official health agencies who work with women, children, their families, and the communities where they live. The training provides participants with foundational knowledge of the role of culture in healthcare delivery, especially for women, children, and their families. Moreover, the training also provides useful cultural skills for health care personnel providing care at every level and in any capacity.

Secondly, the training focuses on how culture influences healthcare and what a provider can do to provide competent care. Participants also identify their own strengths and limitations related to cultural competence using cultural self-assessments provided at the beginning of the workshop. Finally, the training identifies strategies, develops skills, and identifies resources to promote the participants' own cultural competence.

The Department's commitment to this project required that the Department send a person to Tennessee to get trained in a program to come back to the state and, in turn, train 150 participants. In August 2005, Olinda Morales, the person appointed by the Commissioner of the Department, attended a Train the Trainer workshop.

During the months of September through November 2005, a group of six employees prepared to provide the Meaningful Exchange workshop. Such preparation consisted of securing Title V funds from the Family Health Division of the Department to provide support for eight training sessions, including reserving an appropriate location, and registering participants. The training was provided from December to March 2006, and consisted of a total of eight sessions. A total of 178 participants were trained, exceeding the Department's goal of 150 participants. The Department is preparing to train 15 more trainers to move to the second phase of this program.//2007//

/2008/ Although Latinos represent 9% of CT's population, they account for 40% of the state's uninsured, 25% of AIDS cases and 30% of Chlamydia cases. The Public Health Initiatives Branch has convened an internal Health Disparities workgroup. The Office of Multicultural Health hosted the Region 1 Minority Health Conference that was well attended. FHS staff participated in the Region1 OWH meeting to discuss health issues identified by the Tribal Nations; the data from this group will be included in the next five-year MCH needs assessment.//2008//

F. Rural Health

The Connecticut definition of rural, adopted June 2004 by the ORH Advisory Board, uses the 2000 U.S. Census data and OMB designations. All towns in a designated Micropolitan Statistical Area with a population less than 15,000 and those towns in Metropolitan Statistical Areas with a population of less than 7,000 are designated rural for the State of Connecticut. Of the 169 towns in CT, there are 29 with populations of less than 7,000 (22). Specific concerns identified for rural

Connecticut include: emergency medical services, transportation, recruitment and retention of adequate workforce, a decreasing social services safety-net, mental health, oral health, and others. The Primary Care Office (PCO), located in the Family Health Section has taken on a formal role in meeting with the staff of the Office of Rural Health, and PCO staff has recently been appointed to the ORH Advisory Board. The Title V program will continue to support the PCO and its collaborative efforts with the ORH and provide technical assistance to the ORH as they better assess and document the needs of the rural health community.

/2008/ A recent CT Office of Rural Health survey identified concerns regarding transportation, substance abuse, domestic violence, oral health care & mental health services in rural CT./2008//

G. Other Vulnerable Populations

The Department has been interested in the health needs of vulnerable women and children, many of whom face barriers to care which are not addressed by the state's managed care system. These populations include the uninsured, single mothers transitioning from welfare to work, homeless mothers and children, incarcerated women, adolescents who are concerned with confidentiality (parent involvement in their health care), immigrant and undocumented populations, infants who experience delays in newborn Medicaid eligibility determinations, and providers who are not prepared to deal with the multiple social and economic problems facing many of their patients. This is especially true in areas where hospital based clinics have closed and patients are referred to private practitioners.

Incarcerated Women's Health: The role of the Title V program has been to work collaboratively with other state agencies and community based organizations to address the issues of this vulnerable population. The DPH functioned as a conduit for bringing together key state agencies to address transitioning soon-to-be-released women, from York Correctional Institute (YCI), Connecticut's only female prison, back to the community healthy. As a result of this process, the DSS designated Medicaid eligibility workers to process Medicaid applications for inmates just prior to their release date. This is a model which can be replicated in the male correctional institutions throughout the state.

/2007/ The DPH is pursuing the opportunity to work with YCI on addressing intimate partner violence that occurs both internally and externally (those who experience IPV prior to and during incarceration) to equip those who need resources to address potential IPV upon release. YCI is CT's only female prison/jail. YCI has a 1,500 inmate capacity and approximately 5,000 women move through the facility each year./2007//

/2008/ FHS Staff are working with DOC staff to develop an MOA to implement a gender responsive IVP curriculum for both DOC staff and inmates at YCI. /2008//

Homelessness: The DPH contracted with an independent public health consulting firm to assess and evaluate the health care access infrastructure for the Homeless population in order to enhance their access to health services. A statewide Homeless Health Advisory group, including governmental, public/non-for-profit, private, faith based, and advocacy organizations, was formed to guide this evaluation study. This study involved needs assessment of shelters, and their health care systems/infrastructure for the homeless population, and key informant interviews. The study is completed and the role of Title V is to identify and conduct intervention strategies to promote and enhance the health status of the homeless population.

Male Involvement: The FHS recognized that the health of fathers and men impacts the health of women, children and families. The role of Title V has been to become an active participant on the New Haven Family Alliance-Male Involvement Network and the DSS' Fatherhood Initiative Council to conduct population based activities by developing and disseminating consumer and provider educational materials regarding the importance of men's health and the impact on maternal and child health. /2008/ DPH is a member of the Adolescent Paternity Workgroup convened by the Consultation Center in New Haven. The DPH is collaborating with the Hartford Community Court & Department of Social Services by providing a parenting class for adolescent fathers in the judicial system.//2008//

III. Health Priorities

A. MCH Priorities

In 2004, the Department invited a selected group of experts in the maternal and child health field in the State, including healthcare professionals, community advocates, and representatives from state agencies, to map out a perinatal health plan with priority goals for the State to address. This Statewide group adopted the following as a standard definition of perinatal health to guide efforts in the maternal and child health "comprehensive and integrative continuum of health care from the preconception period through the prenatal and postnatal periods. Care should be sensitive to ethnic and cultural diversity with an emphasis on the family and father involvement".

The Perinatal Advisory Group identified nine goals to address perinatal health. These goals include: 1. Reduce perinatal health disparities, particularly preterm/low birth weight births and infant and fetal mortality between and among racial and ethnic groups; 2. Improve access to a continuum of health care services for underserved and/or un-served women of child bearing age; 3. Enhance and encourage male involvement in the continuum of women's health care from preconception, prenatal through postnatal periods; 4. Reduce pregnancies and poor birth outcomes among adolescents; 5. Reduce unintended pregnancies for all women; 6. Reduce recognized birth-related risk factors for children with special health care needs; 7. Improve the state's system capacity to collect high quality maternal child health data and disseminate in a timely manner; 8. Improve access to mental health, substance abuse treatment and dental health services which can improve the overall health for pregnant and postpartum women; and 9. Improve inter-provider communication strategies regarding perinatal health care delivery. The Perinatal Advisory group will be reconvened to prioritize and provide guidance to the Title V program regarding the implementation of the nine identified goals and objectives. This statewide perinatal strategy will provide the needed structure to better address the MCH federal and new state performance measures.

/2008/ The State Perinatal Advisory Group was merged with the recently reconvened MCH Infoline Advisory Group.//2008//

B. CYSHCN Priorities

The Children with Special Health Care Needs program includes the priority areas specific to this population in its program design. In order to enhance CYSHCN services, the Family Health Section (FHS) within DPH has redesigned the program by requiring the Center to operate a program that is family-centered with family participation and satisfaction; performs early and continuous screenings; improves access to affordable insurance; coordinates benefits and services to improve access to care; participates in spreading and improving access to medical home and respite service; participates in developing a community-based service system of care, and promotes transition services for youth with special health care needs.

The Department has been leading the State in the implementation of the State Early Childhood and Comprehensive System's grant (SECCS). This initiative is called Early Childhood Partners (ECP) and the process brought together eight State agencies and statewide institutions, with extensive input from numerous community interests since October 2003 to create an outcome-driven Strategic Plan to support all Connecticut families to ensure that their children arrive at school healthy and ready to succeed. The strategic plan will be used as a framework for the operations of the newly established Children Cabinet by Connecticut legislators and Governor. The Plan aims at creating an integrated service system that incorporates comprehensive health services, early care and education, and family support and parent education to ensure the sound health and full development of all children. The system would provide for easy entry, clear navigation, and appropriate supports for all families and includes six priority goals for the State, which includes: 1. Every child, adolescent and pregnant woman in Connecticut will have access to comprehensive, preventive, continuous healthcare through a family-centered Medical Home; 2. All children will have access to affordable, quality early care and education programs and an effective transition to Kindergarten; 3. All parents will have access to the support and resources they need to raise healthy children; 4. Build the capacity for planning, resource allocation and monitoring of the early childhood services system through a collaborative local or regional early childhood structure for all Connecticut towns; 5. Create a state level infrastructure to guide, support, and monitor implementation of the Early Childhood Partners plan; and 6. Promote public education and public will through a broad communication and engagement strategy.

/2007/ The ECP 2006-2008 Implementation plan consists of 4 goals, which include 1) To expand the number of pediatric practices and clinics providing medical homes for all children, particularly those with special health care needs; 2) To increase the number of parents and providers trained as partners and participating in their communities as advocates for children; 3) To meet the developmental needs of children through access to comprehensive health, mental health and education consultation for families and early care and education providers; and 4) To increase the coordination and the exchange of information between state agencies and organizations that address early childhood services.//2007//

/2008/ The ECP staff collaborated with the Children's Trust Fund and utilized ECP funds to conduct 2 Ages & Stages Questionnaire (ASQ) trainings for health care providers.//2008//

C. Data and MCH Impact

Consistent with the HP 2010 objectives, Connecticut gives priority to MCH surveillance through such activities as Pregnancy Related Mortality Surveillance, Child Health Profile (CHP) Database, DocSite for data management of Children and Youth with Special Health Care Needs (CYSHCN), Fetal and Infant Mortality Review, and Vital Records data collection and analysis, to name a few. The CHP is a database located in the FHS within DPH to hold information of newborns on lab screening tests, hearing tests, and birth defects reported by birth facilities through the electronic reporting system. The CHP is linked to Electronic Vital Records (EVR). The DocSite is a web-based system used by medical homes and regional medical home support centers to collect and report CYSHCN information to DPH. Emphasis is being placed on the necessity to develop better linkages among our many sources of data. All Title V activities and programs are designed to promote and protect the health of Connecticut's mothers, children and adolescents, and children with special health care needs.

/2007/ The CT Pregnancy Risk Assessment and Tracking System Survey (PRATS) survey was designed to identify risk factors associated with adverse pregnancy and birth outcomes. The survey, mailed to 4500 postpartum women in CT, obtained a 44.2% response rate. The initial report was released this year and is posted on the DPH website.//2007//

Improvements to the CHP database continue. Planned enhancements include the

completion of linkage of death records into the CHP database. The matching routine will link corresponding birth newborn hearing screening results; and the commencement of the linkage of the CHP database with a fourth database.

Work towards the creation of a data warehouse of high-quality linked child health data, which has been titled HIP-Kids (Health Informatics Profile for CT Kids), will continue in the upcoming year. DPH continues to pursue funding for full implementation of HIP-Kids from both external and internal efforts. Once funded, implementation will progress using the three-year technical strategic plan. Please see SPM 1 for more information.//2007//

/2008/A presentation of the PRATS data was held; the PRATS survey will be repeated in 2009. The first Birth Defects Registry Report for 2001-2004 has been released and is posted on the DPH website.//2008//

There is growing emphasis on the development of data systems and linkages. Staff are coordinating the Memorandum of Understanding (MOU) between DPH and DSS regarding data exchanges. The purpose of this MOU is to improve public health service delivery and public health outcomes for low-income populations through the sharing of available Medicaid, HUSKY Plan Part B, HUSKY Plus and Title V data. The initial MOU included three addenda addressing the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and on Children Receiving Title V Services and Medicaid data. Linked data will be analyzed and used to guide MCH programs.

/2008/ The Data Sharing MOU related to the linkage of birth and Medicaid data was amended to include a linkage to clients under the fee-for-service component of Medicaid.//2008//

The need to strengthen data linkages was identified in the five-year needs assessment. The Title V program will be taking a lead role in securing a contract with the CT Hospital Association to obtain hospital discharge data. The acquisition of this data set will enhance case ascertainment for the maternal mortality surveillance program, enhance the Crash Outcome Data Evaluation System (CODES) database and provide additional data for the Asthma and other MCH programs both at the state and local levels.

/2007/The Family Health Section obtained the inpatient hospitalization discharge and Emergency Department data for the period 2000-2004 in May 2006. These data are being reviewed and corrected regarding quality assurance issues and then will be shared across approximately 12 programs within DPH seeking these data for enhanced case ascertainment and surveillance. There is also work in progress to store these data on DPH's Public Health Information Network that meets national infrastructure and security standards including controlled access to and exchange of data.//2007//

/2008/ A data management module for the in-patient hospitalization and ED data was created and will be placed on DPH's Public Health Information Network to facilitate the creation of data extracts for various DPH programs.//2008/

In fall 2004, DPH executive staff expressed goals for improved and enhanced communications between and across programs that reduces barriers to effectiveness and efficiency across programs. To address these goals, the Virtual Child Health Bureau (VCHB) was formed. The VCHB is in the process of developing a Plan to coordinate its activities. With a special emphasis on child health, the VCHB has as its mission collaborations across branches within DPH to ensure optimum health of all children in the state. Within the VCHB, an interdepartmental group

of database users and managers was formed called the VCHB Data Committee. The Data Committee now seeks to find meaningful ways to share child health information broadly across the Department. Using needs identified by staff across DPH, the Data Committee drafted a set of recommendations in spring, 2005, which may help guide its progress toward this goal. These recommendations need to be discussed, adopted and implemented. Some of these recommendations complement the state MCH priorities identified for the next five years. /2008/ FHS staff are active members of the VCHB Cabinet & its data subcommittee.//2008//

IV. Conclusion

It is the role of Connecticut's Title V program, through funding of direct/enabling, population-based, and infrastructure building services, to address prioritized needs and gaps in services for the target populations. Community based programs are funded to provide direct and enabling services, such as case management and outreach. Population-based services include disease prevention, education, and the empowering of MCH populations about health and health related issues. Infrastructure building services include needs assessment, policy development, quality assurance, information systems development and management, and training that support individual, agency, and community health efforts.

The Title V Director utilizes various mechanisms to determine the importance, magnitude, value and priority of competing factors, which impact the MCH health services delivery in the State, which includes: 1. conducting ongoing statewide assessments (MCH five-year needs assessment, breastfeeding practices of African American women, bereavement services for families experiencing a fetal or infant death, Pregnancy Risk Assessment Tracking System [PRATS], Adolescent Health, Healthcare for the Homeless, CYSHCN Needs Assessment, etc.); 2. reviewing and analyzing Title V programs quarterly reports submitted by all contractors, which includes both quantitative and qualitative information. This information is reviewed and provides valuable input into MCH programming, as well as serving as a vehicle for identifying and documenting emerging MCH issues; 3. conducting quarterly technical assistance meetings with the MCH contractors (i.e., FIMR, RFTS, etc.). This provides an additional opportunity for contractors to share information with Title V program staff and their colleagues regarding MCH issues that they are facing as community-based providers of services. Other external factors, which cannot be overlooked and impact the importance of MCH service delivery, and MCH programming have been previously discussed (economy, insurance status, legislation, etc.). The combination of the ongoing assessments, quarterly reporting data, technical assistance meetings and site visits, as well as other sources, assists the Title V Director in addressing the MCH needs and determining priorities for the State.

/2008/ Addressing health disparities within the MCH population continues to be an ongoing priority for the DPH. Overall CT's birth outcomes compare favorably, however, subgroups do not fair as well. MCH outcome data by race and ethnicity paints a picture of a much different CT. The FHS has taken a more data driven approach to its MCH program design and implementation, which will impact programs available to those identified most in need.//2008//

Please refer to the attachment to this section for all Tables and Figures, and for Works Cited.

An attachment is included in this section.

B. Agency Capacity

Authority for the Maternal, Infant, and Child and Adolescent Health Programs is derived from the CT General Statutes and Title V Federal Grant Program Requirements. The following describes the statutes that support DPH authority for MCH programs.

Sec. 4-8(1949) Qualifications, Powers and Duties of Department Head. This statute authorizes the transfer of Title V funds to the Department of Social Services (DSS).

Sec 14-100a PA 05-58(2005) Child Restraint systems. The former infant/child seat belt law was amended to address rear-facing child seats, use of booster seats, and increase the minimum age to 6 years old or 60 pounds. The injury prevention program is impacted by this statute.

Sec. 10-206.PA 04-221(1940-2004) Health assessments. Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments conducted by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant, or by the school medical advisor. The assessment includes: a physical examination; chronic disease assessment (i.e., asthma, lead levels), an updating of immunizations; and vision, hearing, speech and gross dental screenings. The assessment also includes tests for tuberculosis, sickle cell anemia or Cooley's anemia.

Sec 19a-2a PA 93-381(1993) Powers and duties. The Commissioner of DPH shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of DPH and the Public Health Code. He shall have responsibility for the overall operation and administration of DPH. All Title V Programs are impacted by this statute.

Sec. 19a-4j PA 98-250(1998) Office of Multicultural Health. The responsibility of the office is to improve the health of residents by eliminating difference in disease, disability and death rates among ethnic, racial and cultural populations. All Title V Programs are impacted by this statute. Although the Office was eliminated through layoffs in 2003, activities continued and the Office was re-established in 2005.

Sec. 19a-4i PA 93-269(1993) Office of Injury Prevention. This office coordinates and expands prevention and control activities related to intentional and unintentional injuries, including surveillance, data analysis, integration of injury focus within DPH, collaboration, support and develop community based programs and develop sources of funding. This statute impacts many Title V Programs since injury is the leading cause of death for the 1 to 19 year old age population.

Sec. 19a-7 PA 75-562(1975) Public Health Planning. DPH shall be the lead agency for public health planning and shall assist communities in the development of collaborative health planning activities. All Title V Programs are impacted by this statute.

Sec. 19a-7a PA 90-134(1990) State goal to assure the availability of appropriate health care to all state residents. The goal of the state is to assure the availability of appropriate health care to all residents, regardless of their ability to pay. All Title V programs are impacted by this statute.

Sec. 19a-7c PA 90-134(1990) Subsidized non-group health insurance product for pregnant women. DPH with DSS may contract to provide a subsidized non-group health insurance for pregnant women who are not eligible for Medicaid and have incomes under 200% of the federal poverty level. Healthy Start, Comadrona, Family Planning, Community Health Centers (CHCs) are the programs most affected by this statute.

Sec. 19a-7f PA 91-327(1991) Childhood immunization schedule. An immunization program shall be established by DPH, cost of vaccine will not be a barrier to age-appropriate vaccination. CHCs and School Based Health Centers (SBHCs) are the programs most affected by this statute.

Sec. 19a-7h PA 94-90(1994) Childhood immunization registry. The registry shall include

information to accurately identify a child and to assess current immunization status. CHCs and SBHCs are the programs most affected by this statute.

Sec. 19a-7i PA 97-1(1997) Extension of coverage under the Maternal and Child Health Block Grant. DPH shall extend coverage under Title V of the SSA to cover underinsured children with family incomes between 200% -300% of the federal poverty level. If allowed by federal regulations, such expansion may be included for reimbursement under Title XXI of the SSA. CYSHCN programs are most affected by this statute.

Sec. 19a-17b, PA76-413(1976) Peer Review: Definitions, immunity; discovery permissible from proceedings. There shall be no monetary liability against any person who provides testimony, information, records, etc. The proceedings of a medical review committee are not be subject to discovery or introduction into evidence in any civil action for or against a health care provider arising from matters subject to evaluation and review by such committee. FIMR and Pregnancy Related Mortality Surveillance are the programs most affected by this statute.

Sec. 19a-25 PA 61-358(1961) Confidentiality of records procured by DPH or directors of health of towns, cities or boroughs. Describes the restricted use and confidentiality of all information, records of interviews, written reports, statements, notes, memoranda or other data procured by DPH or its representatives for the purpose of reducing the morbidity or mortality from any cause shall be used solely for the purposed of medical or scientific research and for disease prevention and control. All programs are influenced by this statute. FIMR and Pregnancy Related Mortality Surveillance are the programs most affected.

Sec. 19a-32(1949) Department authorized to receive gifts. DPH is authorized to receive, hold and use real estate and to receive, hold, invest and disburse money, securities, supplies or equipment offered it for the protection and preservation of the public health and welfare by the federal government or by any person, corporation or association, provided such assets shall be used only for the purposes designated. All Title V Programs are impacted by this statute.

Sec. 19a-35 PA 35-240(1935) Federal funds for health services to children. DPH is designated as the state agency to receive and administer federal funds which may become available for health services to children. Title V Programs serving children are most affected by this statute.

Sec.19a-48(1949) Care for Children with Cerebral Palsy. DPH shall furnish services for children who have cerebral palsy including locating the children, providing medical, surgical, corrective and allied services and care, and providing facilities for hospitalization and aftercare. CYSHCN programs are most affected by this statute.

Sec.19a-49(1961) Services for Persons with Cystic Fibrosis. DPH shall establish and administer a program of services for children and adults suffering from cystic fibrosis. CYSHCN programs are most affected by this statute.

Sec. 19a-38. PA 156(1965). Fluoridation of public water supplies. Wherever the fluoride content of public water supplies serving 20,000 or more persons supplies less than 8/10ths of a milligram per liter of fluoride, whoever has jurisdiction over the supply shall add a measured amount of fluoride so as to maintain the fluoride content. The Oral Health program is affected by this statute. ***/2008/The Oral Health Program has been renamed the Office of Oral Public Health./2008//***

Sec. 19a-50 PA 39-142 PA 37-430(1937, 1939) Children crippled or with cardiac defects. DPH is designated to administer a program of services for children who are crippled or suffering from cardiac defect and to administer federal funds which may become available for such services. CYSHCN programs are most affected by this statute.

Sec.19a-51 PA 63-572(1963) Pediatric Cardiac Patient Care Fund. There shall be a Pediatric Cardiac Patient Care Fund to be administered by DPH and to be used exclusively for medical,

surgical, preoperative and postoperative care and hospitalization of children, residents, who are or may be patients of cardiac centers in this state. CYSHCN programs are most affected by this statute.

Sec. 19a-52(1981) Purchase of equipment for handicapped children. DPH may, purchase wheelchairs and placement equipment directly. CYSHCN programs are most affected by this statute.

Sec. 19a-53 PA 33-318(1933) Reports of physical defects of children. Each health care provider who has professional knowledge that any child under 5 years of age has any physical defect shall mail to DPH a report stating the name and address of the child, the nature of the physical defect and such other information. The CYSHCN Registry is supported by this statute.

Sec. 19a-54 PA 33-266(1933) Registration of physically handicapped children. Each institution supported in whole or in part by the state shall report to DPH, the name and address of each child under 21 years of age who is physically handicapped for whom application is made for admission, whether such child is admitted or rejected. The CYSHCN Registry is supported by this statute.

Sec. 19a-55 PA 65-108(1965, 2002) Newborn infant health screening. Each institution caring for infants shall cause to have administered to every infant in its care an HIV-related test, and a series of tests for disorders as listed in the attachment to this section. This bill has been amended to expand testing, as listed in the supporting document attached.

Sec. 19a-56a PA 89-340(1989) Birth defects surveillance program. The program shall monitor the frequency, distribution and type of birth defects occurring in CT on an annual basis. DPH shall establish a system for the collection of information concerning birth defects and other adverse reproductive outcomes. The CYSHCN Registry is supported by this statute.

Sec. 19a-56b PA 89-340(1989) Confidentiality of birth defects information. All information collected and analyzed pursuant to section 19a-56a shall be confidential insofar as the identity of the individual patient is concerned and shall be used solely for the purposes of the program. The CYSHCN Registry is supported by this statute.

Sec 19a-59 PA 81-205(1981) Program to Screen Newborn Infants for Hearing Impairment at Birth. Each institution that provides childbirth service will include a universal newborn hearing screening program as part of its standard of care and establish a mechanism for compliance review. DPH will establish a plan to implement and operate a program of early identification of infant hearing impairment. Newborn Hearing Screening Program is supported by this statute. /2007/This program is now called the Early Hearing Detection and Intervention Program.//2007//

Sec. 19a-59a PA 82-355(1982) Low Protein modified food products and amino acid modified preparations for inherited metabolic disease. DPH may purchase prescribed special infant formula, amino acid modified preparations and low protein modified food products directly. CYSHCN programs are supported by this statute.

Sec. 19a-59b PA 83-17(1983) Maternal and Child Health Protection Program (MCHPP). DPH shall establish a maternal and child health protection program to provide outpatient maternal health services and labor and delivery services to needy pregnant women and child health services to children less than 6 years of age. Comadrone, Right from the Start, and Healthy Start are supported by this statute.

Sec. 19a-59c PA 88-172(1988) Administration of federal Special Supplemental Food Program for Women, Infants and Children in the state. DPH is authorized to administer the WIC program in the state, in accordance with federal law and regulations. WIC is supported by this statute.

Sec. 19a-60 PA 45-462(1945) Dental services for children. DPH may furnish dental services for children free of charge where the cost of necessary service would be a financial hardship to their parents. CHCs and SBHCs are affected by this statute.

Sec. 19a-90 PA 41-255(1941) Blood tests of pregnant women for syphilis. Each physician giving prenatal care to a pregnant woman in this state shall take a blood sample within 30 days from the date of the first examination and during the final trimester, and shall submit such sample for a standard serological test for syphilis. Family Planning, CHCs and SBHCs are affected by this statute.

Sec. 19a-110 PA 71-22(1971) Report of lead poisoning. Defines reporting requirements to DPH regarding blood lead levels equal to or greater than 10 micrograms per deciliter of blood or any other abnormal body burden of lead. CHCs and SBHCs are affected by this statute.

Sec. 19a-62a(2000) Pilot program for early identification and treatment of pediatric asthma. DPH, with DSS, shall establish pilot program for the early identification and treatment of pediatric asthma. The DPH Asthma Program is impacted by this statute.

/2008/Sec. 47-48 of Public Act 06-188 (2006) Medical home pilot program. The Commissioner of Public Health, in consultation with Medicaid managed care organizations, may establish a medical home pilot program in one region of the state in order to enhance health outcomes for children, including children with special health care needs, and evaluate such pilot program to ascertain specific improved health outcomes and cost efficiencies achieved not later than one year following the establishment of such program. The Children and Youth with Special Health Care Needs program is impacted by this Act.

Sec. 51 of Public Act 06-195 The Commissioner of Public Health shall establish an ad hoc committee for the purpose of assisting the commissioner in examining and evaluating statutory and regulatory changes to improve health care through access to school based health centers, particularly by persons who are underinsured, uninsured or receiving services under the state Medicaid program.//2008//

CYSHCN Program Capacity in CT

The CYSHCN program provides care coordination, advocacy and family support to CYSHCN regardless of enrollment financial status. A review of the CYSHCN program resulted in a new infrastructure and capacity building strategy to meet the Healthy People 2010 goals of parent partnership, comprehensive care within a medical home, adequacy of insurance, screening for special needs, community-based service system and transition to all aspects of adult life. The CYSHCN/Regional Medical Home Support Centers (RMHSCs) are responsible for providing services to children receiving Supplemental Security Income benefits who meet program eligibility criteria. The 5 centers are The Stamford Health System serving Southwest CT, Yale School of Medicine, serving South Central CT, St Mary's Hospital serving Northwest CT, LEARN serving Eastern CT and Charter Oak Health Center serving North central CT.

/2008/Contracts for LEARN and Charter Oak Health Center were terminated in 10/06 due to non-compliance with contract terms. Based on the feedback from a retreat, the program is transitioning from a Center based approach to a more community based practice approach.//2008//

The RMHSCs will enhance the capacity for medical homes in the region to screen children and assist the medical homes through community-based health care systems. There are an estimated total of 120,000 CYSHCN in CT. The second purpose of the RMHSCs is to improve availability of programmatic and health care service data on CYSHCN for evaluation and development of quality programs. Data and practice management for this new approach will be supported through Doc Site, a quality assurance web-based program. Multi-state agency Memoranda of

Understanding (MOUs) will be utilized to support care coordination and data sharing on CYSHCN.

/2008/DocSite is no longer being used; DPH staff developed an Access database./2008//

Care Coordination, the core of both the RMHSCs and the medical homes will be technically supported to assure that there is an inter-agency collaboration in meeting the needs of the CYSHCNs. RMHSCs will also support families with community-based resources, family networking and building parent partnerships in medical homes. Funds for durable medical equipment, prescriptive medications, special nutritional formulas and respite care needs for the uninsured and underinsured families are available on a limited basis.

/2008/ Three RFPs have been issued to better operationalize the medical home project in CT; one for care coordination, one for administering the respite/extended services funds & one for provider and consumer outreach and education./2008//

Regional Family Networks (RFN) will be groups of parents and/or caregivers of CYSHCN whose primary responsibilities within this system include family support services and quality assurance for the service delivery system. RFN will serve as an additional support to the care coordinators within the RMHSCs on family-centered training and capacity building.

/2008/ RFN will continue with the new contracts, family support will be funded through one contract and not through five to ensure a more cohesive group that will provide uniform supports and services./2008//

A CT Medical Home Learning Collaborative resulted from participation in the National Institute of Child Health Quality's (NICHQ) Medical Home Learning Collaborative with the purpose of improving care for CYSHCN by implementing the AAP's Medical Home concept. The collaborative meets quarterly and is open to all providers interested in building their capacity as a medical home, especially in meeting the needs of CYSHCN. A Medical Town News is published quarterly by DPH and posted on DPH's website.

The United Way's INFOLINE (211) Child Development Infoline (CDI) is the primary intake source for CYSHCN. CDI caseworkers assess the caller's situation, and make referrals to CT Birth to 3 System, Help Me Grow, Preschool Special Education, and/or CYSHCN/RMHSC. The 211 component of Infoline, funded as CT's Maternal and Child Health Information and Referral Service, will work closely with the RMHSCs on their resource information updates.

/2007/DPH initiated a Medical Home Advisory Council, which is comprised of representatives from state agencies, community-based organizations and parents of CYSHCN. Their mission is to provide guidance to DPH in its efforts to improve the community-based system of care for CYSHCN./2007//

Title V Partnership Programs for Pregnant Women, Mothers and Infants

Breastfeeding Initiative: Initially funded through the SSDI Initiative and in-kind support, staff are working to develop internal mechanisms and evaluate the DPH's capacity to collect population based breastfeeding data. As a result of these efforts, in January 2004 the Electronic Newborn Screening Database started to collect data from all birthing hospitals on the mother's intent to breastfeed.

/2007/DPH has identified a state Breastfeeding Coordinator who is co-funded by the MCHBG and USDA/WIC funding./2007//

Comadrona: DPH contracts with the Hispanic Health Council of Hartford to provide culturally appropriate intensive case management services to pregnant Latina and African-American women and their children who reside in the greater Hartford area.

/2008/ An RFP will be issued for this program in 2006-7./2008//

Family Planning: Through its contract with Planned Parenthood of CT, Inc., comprehensive reproductive health services are available in 15 locations across the state. Family Planning promotes decreasing the birth rate to teens age 15-17, preventing unintended pregnancy, and increasing access to primary reproductive health care.

/2007/There are now 16 sites//2007//

Fetal and Infant Mortality Review (FIMR): Six high-risk communities are funded to examine confidential, de-identified cases of infant deaths, with a goal of understanding how local social, economic, public health, educational, environmental and safety issues relate to infant deaths in order to improve community resources and service delivery. To complement and expand the FIMR process, Perinatal Periods of Risk will be introduced next year.

/2007/DPH will develop a statewide surveillance system to identify health related FIM issues to gain understanding of how and why communities take action to prevent fetal and infant deaths, and identify additional geographic areas of need.//2007//

/2008/An MOA between DPH and UCONN was executed to develop a statewide surveillance system to better address fetal and infant mortality.//2008//

Healthy Choices for Women and Children (HCWC): HCWC provides intensive case management services to low income, pregnant and postpartum women who abuse substances or are at risk for abusing, or whose partner abuses substances, and their children from birth to age 3, who reside in the city of Waterbury or surrounding communities. Referrals and linkages to community-based health and health related services are provided.

Healthy Start: This statewide collaboration between DSS and DPH aims to reduce infant mortality, morbidity and low birthweight, and to improve healthcare coverage and access for children and eligible pregnant women. Last year, DPH signed a collaborative agreement with the federal New Haven Healthy Start Program. Several priorities emerged as common concerns: Male Involvement; MCOs; Care Coordination; Consortium Development; FIMR/PPOR; and Data Collection.

/2008/ DPH has renewed its letter of agreement with the Federal New Haven Healthy Start Program.//2008//

Maternal and Child Health Information and Referral Service (MCH landR): DPH contracts with the United Way of CT to administer the toll-free MCH hotline that provides information on health and related services. Services are accessible to non-English speaking callers and to speech/hearing impaired callers. More information on INFOLINE is noted above.

/2008/ United Way of CT has reconvened its MCH Advisory Committee. The DPH Perinatal Advisory Committee has been integrated with the MCH Advisory Committee.//2008//

Oral Health: The Office of Dental Public Health has a comprehensive public health strategy for the prevention of oral diseases and disorders in CT's children and their families. The Office works with the American College of Obstetrics and Gynecology and the March of Dimes to address oral health during the prenatal period, and has partnered with DSS to implement a Dental Loan Repayment Program for dentists and hygienists to work in underserved areas of the state. Work is currently underway to develop a new state oral health plan.

/2008/The Office of Dental Public Health has been renamed the Office of Oral Public Health.//2008//

/2007/In 2005, DPH received a grant award from HRSA to develop a statewide public awareness campaign regarding perinatal depression. The statewide Perinatal Depression Workgroup successfully recruited consumers and professionals of diverse backgrounds to participate.//2007//

Pregnancy Related Mortality Surveillance (PRMS): An OB-GYN consultant conducts maternal

mortality reviews and based on findings, provides education to medical providers to prevent future maternal deaths.

/2007/A report is near completion for PRMS for the decade 1991-2000.//2007//

Right from the Start (RFTS): Located in four communities, the RFTS program provides intensive case management services to pregnant and/or parenting teens. Services provided by community-based contractors must include: intensive case management; outreach and case-finding activities; promotion of breastfeeding; integration of the USPHS/Smoke Free Families Smoking Cessation Intervention model; and public awareness activities. Services must be comprehensive, culturally appropriate, community-based and family centered.

/2008/An RFP will be issued in 2006-7 to provide case management services to pregnant women and teens to promote healthy birth outcomes in up to 3 communities in the state.//2008//

Sudden Infant Death Syndrome (SIDS): In previous years, DPH provided bereavement services to families statewide who experienced a sudden infant death, based on referrals from the Office of the Chief Medical Examiner. Services included home visits, referrals to community-based services, and follow-up. A statewide assessment of cultural appropriateness of bereavement services is currently being conducted. Upon completion, MCHBG funding will be allocated to expand access to and awareness of bereavement services for fetal and infant mortality, including SIDS events.

/2007/ In 2005, there were 11 SIDS events in the state. As a result of the statewide bereavement assessment, DPH is developing an Infant Mortality public awareness campaign targeted to the African American community. This campaign will be in collaboration with the Federal New Haven Healthy Start Program.//2007//

/2008/ In 2006, there were 12 SIDS events in the state.//2008//

SSDI: CT is focusing on 3 main activities: assess and enhance programmatic data collection systems in order to improve DPH's ability to report on the many required outcome measures; expand the linkage of the Birth and Supplemental Nutrition Program for Women, Infants and Children (WIC) to include a linkage with the state Medicaid eligibility files; and develop and evaluate a database for community-based providers who participate in the CYSHCN Medical Home Learning Collaborative.

/2008/ The 2007-2011 SSDI Project goals have been modified to further enhance the FHS programmatic data collection systems to improve& increase the availability of quality data for the MCHBG and MCH programs.//2008//

The Injury Prevention Program (IPP): In collaboration with its many partners, the program provides resource materials, and technical assistance on injury prevention issues for Title V funded programs and other community service providers. The Program also facilitates the Interagency Suicide Prevention Network.

/2007 IPP was transitioned from FHS to the Health Education, Management and Surveillance Section (HEMS). FHS maintains a strong collaboration with this program.//2007//

/2008/FHS provides to the IPP for the developing Injury Surveillance System; this includes obtaining in-patient hospitalization and ED data from the CT Hospital Association.//2008//

Title V Partnership Programs for Children and Adolescents, Age 1 through 22 years.

Comadrona: As described above.

Healthy Start: As described above.

School Based Health Centers (SBHC): DPH funds 63 SBHCs in 18 communities, serving students in grades pre-K-12. SBHCs are licensed as outpatient facilities or hospital satellites. They offer services addressing the medical, mental and oral health needs of youth, including crisis intervention, health education, social services, outreach, and substance abuse prevention.

/2007/DPH now funds 65 SBHCs in 19 communities.//2007//

/2008/DPH now funds 68 SBHCs in 20 communities with three additional communities providing ESHS.//2008//

Expanded School Health Services (ESHS): DPH funds 2 ESHS projects. One site focuses on preventing and improving mental health status and service referral for children and youth in a regional school system and one site provides access of physical and behavioral health services to preschool aged children and families who are at risk for learning in one community.

Family Planning: A special effort is made to target services to teens and provide STD screening and treatment, HIV/AIDS screening, and contraception services. Other services include free pregnancy tests and counseling for adolescents at or below 150% federal poverty level, outreach efforts at health fairs, teen life conferences, and statewide events to provide reproductive health and STD prevention literature, as well as conducting community educational programs to teens at risk.

Healthy Choices for Women and Children (HCWC): As described above.

Maternal and Child Health Information and Referral Service (MCH landR): As described above.

Oral Health: DPH funds 6 School Based Programs to improve dental access and services underserved children as well as conduct ongoing surveillance for planning purposes of dental health status of youth through the CT BRFSS.

/2007/DPH now funds 4 School Based programs.//2007//

Right from the Start: As described above.

The Early Childhood Partners (ECP): The ECP Comprehensive Systems Plan aims to create an integrated service system that incorporates comprehensive health services, early care and education, family support and parent education to ensure the sound health and full development of children. The CT Early Childhood Cabinet was established by the State Legislature in 2005 and created CT's early childhood framework: Ready by 5 and Fine by 9. The Cabinet includes the Commissioners of the departments with primary responsibility over early childhood services.

/2007/Please see the program update in the Overview section.//2007//

The Injury Prevention Program (IPP): The CT Young Worker Safety Team, a collaboration of DPH and State Departments of Labor and Education, federal and local agencies, promotes safety of adolescents in the workplace through awareness, education and training activities. The Program, in collaboration with partners to facilitates the Interagency Suicide Prevention Network and participates in the Youth Suicide Advisory Board.

/2007/As described above, IPP was transitioned to the HEMS section.//2007//

Title V Partnership Programs for Children with Special Health Care Needs

Children and Youth With Special Health Care Needs (CYSHCN): Children who are screened for special health care needs and are either uninsured or underinsured may be eligible for durable medical equipment, prescriptive pharmacy and special nutritional formulas. The CYSHCN program also offers a limited respite program based on available funds, and transition services to adult care.

/2008/An RFP was developed and issued for administering the Respite and Extended Services Funds./2008//

Adult and Maternal Phenylketonuria Program (PKU): The 2 Regional Genetic Treatment Centers (UConn Health Center and Yale) maintain current records on all adolescent and adult females in CT with PKU, and serve as genetics consultants for primary care providers throughout the state. Genetic and nutritional counseling and high-risk pregnancy care is provided to adolescent and adult females in CT with PKU.

Genetics: The 2 Regional Genetic Treatment Centers provide access to genetic services for all residents. These services include confirmation testing for newborns identified with abnormal metabolic screening results, prenatal testing, genetic counseling, and ongoing treatment, support for adults with PKU, and high risk pregnancy care for the maternal PKU clients. See the attachment to this section for the list of CT Newborn Screening Panel Disorders.

Oral Health: The Office of Dental Public Health addresses the oral health needs of CYSHCN through health promotion activities, particularly early childhood caries prevention. Oral health promotion and disease prevention is an integral part of the goals, objectives and educational activities of the CYSHCN program.

Pregnancy Exposure Information Services (PEIS): PEIS provides information and referral services via a statewide toll-free telephone number to pregnant women and health care providers concerning the potential teratogenic effects of drugs, maternal illness, and occupational exposure.

/2008/ A total of 988 calls were received by the PEIS hotline, with 967 risk assessments performed and treatment plans developed which included counseling services./2008//

School Based Health Centers: SBHCs provide primary and preventive physical and behavioral health care to CYSHCN who are mainstreamed in school settings. In such cases, they coordinate the care they provide with a child's primary and specialist caregivers, and provide support while the child is in school.

/2007/SBHCs help CYSHCN students transition from a school setting to the community upon graduation by linking them to needed services./2007//

Sickle Cell Program: The 2 State funded Regional Sickle Cell Programs, located at Yale University and CCMC, provide comprehensive care programs that include confirmation testing, counseling, education and treatment for newborns identified with hemoglobinopathies through the NBS program. The Sickle Cell Disease Association of America located in New Haven and Hartford serves youth with transition to adult health providers and provides educational programs to increase community awareness. The Southern Regional Sickle Cell Association enhances testing, counseling, case management in the Southwest region of CT.

/2007/The Hospital of Special Care, in New Britain, is planning to implement sickle cell education/training to health professionals in CT who provide care to those with sickle cell disease./2007//

/2008/A three-day sickle cell certification training was conducted; DPH provided stipends to families/consumers who attended and completed the training./2008//

Universal Newborn Screening: The statewide Universal Newborn Screening (UNBS) program is a

population-based program to test, track and treat all newborns. All newborns are screened for the disorders as listed in the document attached to this section, "CT Newborn Screening Panel." Infants with abnormal screening results are referred for comprehensive testing, counseling, education, and treatment services. The program provides increased public health awareness of genetic disorders, public health education, and referrals.

Universal Newborn Hearing Screening (UNHS): All 30 birthing facilities in the state implemented a UNHS program. Standardized equipment is used to screen all newborns prior to discharge. Hospital staff notify the primary care providers of all infants who are in need of follow-up audiologic testing. Tracking and follow-up of children are conducted at the state level. A web-based reporting system tracks screening results from the birth hospitals. A database is used to track infants referred to audiologists for further evaluation. Those with hearing loss are enrolled in the CT Birth to 3 Program.

/2007/The Early Hearing Detection and Intervention (EHDI) program works with 16 diagnostic audiology centers that provide follow-up testing from the hearing screens conducted at birth.//2007//

Cultural Competency

The Office of Multicultural Health was re-established in April 2005. Cultural Competence language is standard for Title V funded contracts as of July 1, 2003. The FHS staff remain committed to addressing cultural competency during site visits to contractors. Staff has developed an assessment tool to assure that our contractors are providing culturally appropriate services containing key items to be discussed during a site visit. A check box on DPH's Site Visit Monitoring Tool reminds staff to discuss and address cultural competency during site visits.

DPH is presently working with a consultant to assess and evaluate breastfeeding initiation and duration rates of African American and Black women in CT. This consultant will make recommendations to the DPH on ways to improve these rates. DPH collaborated with the CT Breastfeeding Coalition (CBC) to develop and produce a document in English and Spanish describing the breastfeeding laws in CT. This document is mailed to all new mothers in CT.

/2007/Recommendations from the CT Breastfeeding Assessment finalized in 2005 included the use of peer education models, particularly at sites serving the women least likely to breastfeed; engaging Black churches and other Black institutions by recruiting and training church leaders to the benefits of breastfeeding; exploring sources of reimbursement for breastfeeding classes; and publicizing existing free breastfeeding support and information.//2007//

DPH continues to address the health care needs of CT's homeless population by implementing activities outlined in the Healthcare for the Homeless Strategic Plan. DPH has provided funding to 10 CHCs to enhance and strengthen the infrastructures and linkages with homeless shelters while enabling the center's ability to effectively address the healthcare needs of CT's homeless population. The CT Youth Health Service Corp., a program co-funded by DPH and prepares high school youth for careers in the health care field, includes a module in its curriculum regarding working with the homeless population and a module on cultural competency.

/2008/DPH is contracting with the Latino Community Services Inc, to support LCS' Learning Academy which include modules on cultural and linguistic competence, coalition building and other infrastructure building activities.//2008//

An attachment is included in this section.

C. Organizational Structure

Governor M. Jodi Rell has been serving as CT's Governor since July 2004. Dr. J. Robert Galvin, DPH Commissioner since December 2003, serves as the leading health official in CT and advisor to the Governor on health-related matters. Dr. Galvin brings experience in the fields of medicine and public health, as well a strong commitment to serving the people of Connecticut.

DPH is the center of a comprehensive network of public health services, and is a partner to local health departments for which it provides advocacy, certification and training, technical assistance, consultation and specialty services. DPH is a source of health information used to monitor the health status of CT's residents, set health priorities and evaluate the effectiveness of health initiatives. The agency is a regulator of the health community, focusing on health outcomes while maintaining a balance between health status and administrative burden. DPH works to prevent disease and promote wellness through community-based education and programs.

As a result of agency-wide focus groups and strategic planning workshops conducted in late 2004, DPH was reorganized and is now comprised of eight Branches. The Oral Health Program, previously located in the Family Health Section, is now the Office of Oral Public Health and is under the auspices of the Deputy Commissioner. The majority of the Title V activities are located in the Public Health Initiatives (PHI) Branch and a detailed description follows:

Within the Public Health Initiatives Branch, led by Richard Edmonds, MA, Lisa Davis, RN, BSN, MBA serves as the Section Chief of the Family Health Section (FHS) and as the Title V Director. The majority of CT's Title V program activities reside organizationally within the FHS of the PHI Branch, however, other MCH related programs such as oral health, nutrition, childhood lead poisoning prevention, diabetes, tobacco, obesity prevention and asthma are located organizationally in other Sections within the Public Health Initiatives Branch. Other Branches within DPH work cooperatively with Title V funded programs and provide support to programs that promote maternal and child health in the state of CT. For example, in the Laboratory Branch staff analyzes blood specimens from newborns for genetic screening. In the Planning Branch, Health Information Systems and Reporting Section, under the direction of Julianne Konopka, vital record data bases containing information on births, deaths, hospitalizations and risk factors related to maternal and child health are maintained. Epidemiologists within this branch use vital record information to help direct and evaluate Title V program activity.

//2007/ The Childhood Lead Poisoning Prevention program is no longer in the PHI Branch.

The program is now centralized in the Regulatory Services Branch.//2007//

//2008/ Childhood lead poisoning prevention activities are centralized in the Lead Poisoning Prevention and Control Program of the Regulatory Services Branch.//2008//

//2008/ Laboratory Branch staff analyze (1) blood specimens from newborns for genetic screening, (2) blood specimens from children for lead and (3) environmental samples related to lead.//2008//

//2008/ Janet Brancifort, Public Health Services Manager has joined the PHI Branch and has been assigned to the FHS. The Primary Care and Prevention Unit and School and Adolescent Health Unit Supervisors report to Ms. Brancifort.//2008//

The Family Health Section has identified their mission as "improving the health of CT's resident across the lifespan through culturally appropriate surveillance, public education, family-centered interventions and community-based capacity building." FHS's core purpose is "to optimize the health of families" with a vision that "all individuals and families achieve optimal health through appropriate and comprehensive health services." FHS will develop crucial business alliance and work with both internal and external stakeholders as partners to optimize the health of families. The Family Health Section is comprised of three units: Women, Men, Aging & Community Health (WMACH); Child, Adolescent & School Health; and Epidemiology and Injury Prevention. Programs within each unit are defined in the Other (MCH) Capacity section of this report. This structure enables the FHS to focus on and improve the health status of individual members of a family as a cohesive unit. The WMACH unit primarily focuses on the adult members of a family and their public health primary care access point, however, safety net providers such as the CHCs, provide services to clients throughout the entire lifespan. The Child, Adolescent & School Health unit focuses on the pediatric and adolescent members of a family and their public health

primary care access point. The Epidemiology and Injury Prevention unit is structured to focus on supporting the programs with necessary data analyses and program evaluation to track and measure results and ultimately assure that identified objectives are attained and provide quality care/services to Title V clients.

/2007/ The FHS is now comprised of five units. The Child, Adolescent and School Health Unit has been divided into three units: the School and Adolescent Health Unit, the Newborn Screening Unit and the CYSHCN Unit. With the transition of the Injury Prevention Program to another section, the Epidemiology and Injury Prevention unit is now known as the Epidemiology Unit. The ECP project is managed by staff who report directly to the Title V director.//2007//

/2008/ The Women, Men, Aging and Community Health Unit has been renamed the Primary Care and Prevention Unit. This name change more accurately reflects the scope of services provided by this Unit. Other Units in the FHS include: Epidemiology Unit, School and Adolescent Health, Children and Youth with Special Health Care Needs and Newborn Screening. The ECP program is seeking a Health Program Assistant 1 who will function as the ECP Program Coordinator.//2008//

The Office of Dental Public Health is organizationally located outside of the PHI Branch and reports directly to the Deputy Commissioner. Dr. Ardell Wilson, DDS, MPH has been designated as the State Oral Health Director and is responsible for the Office of Dental Public Health. Although organizationally in a different area within DPH, a strong collaborative relationship exists with the MCH programs.

/2007/ New to the Office of Dental Public Health is Linda Ferraro, RDH. FHS Epidemiology Unit continues to support this Office's programs. //2007//

/2008/ The Office of Dental Public Health has been renamed the Office of Oral Public Health.//2008//

Sharon Tarala, RN, JD is the Supervising Nurse Consultant of the WMACH unit. Staff within this unit work on the following programs: CT Youth Health Service Corp, Comadrona, CHCs, Family Planning, FIMR Program, Healthy Choices for Women and Children, Infant Mortality Bereavement Services, Intimate Partner Violence, MCH Referral and Information Services, Pregnancy Related Mortality Surveillance, Primary Care Office, Right from the Start, and Sexual Assault Prevention and Intervention.

/2008/ The Women, Men, Aging and Community Health Unit has been renamed the Primary Care and Prevention Unit.//2008//

Dorothy Pacyna, MS, RN is the Supervising Nurse Consultant of the Child, Adolescent & School Health Unit. The programs served by these staff are: Abstinence Only Education, Expanded School Health Services, SBHCs, Children and Youth with Special Health Care Needs, Genetics Services, Maternal PKU, Pregnancy Exposure Information Service, Sickle Cell Services, Sickle Cell Transition Program, Universal Newborn Hearing Screening, Universal Newborn Screening, Early Childhood Partners Program and Family Advocacy.

/2007/ The CYSHCN program is supervised by Dorothy Pacyna, RN. This unit has been responsible for the implementation of the five Regional Medical Home Support Centers. The FHS Family Advocate who works closely with staff to provide support for all areas of the Medical Home System reports to Ms. Pacyna.//2007//

/2008/ Dorothy Pacyna retired from State service and has been replaced by Mark Keenan, RN, Supervising Nurse Consultant, CYSHCN Program, which now includes Medical Homes and the EHDI Program.//2008//

/2007/ The Newborn Screening Unit, led by Health Program Supervisor Vine Samuels, MPH consists of the Newborn Genetic Screening program (Maternal PKU, Sickle Cell Services and the Pregnancy Exposure Information Services), the Early Hearing, Detection and Intervention program (EHDI) and the newly established Sickle Cell Disease Transition

program.//2007//

/2008/ The EHD program is now part of the Children and Youth with Special Health Care Needs Program. Plans are underway to re-located the metabolic screening program to the State Laboratory.//2008//

/2007/ The School and Adolescent Health Unit, led by Health Program Supervisor Barbara Pickett, includes the Abstinence Only Education program, Expanded School Health Services, School Based Health Centers, and the MCH Referral and Information Services.//2007//

/2008/ The Abstinence Only Education Program is no longer funded in CT.//2008//

Marcia Cavacas, MS, Epidemiologist 4, is the supervisor for the Epidemiology and Injury Prevention Unit. Programs in this unit include the Child Health Access Project, Crash Outcome Data Evaluation System (CODES), Statewide Systems Development Initiative (SSDI), the Children with Special Health Care Needs Registry, and the Injury Prevention Program.

/2007/ With the transition of the Injury Prevention Program to another section, this is now known as the Epidemiology Unit. The Epidemiology Unit seeks to identify, collect, and analyze population-based MCH data and create new systems that complement existing data and that will enhance capacity for programmatic planning, evaluation and surveillance.//2007//

/2008/The CODES project was moved to the HEMS Section where the Injury Prevention Program resides. The Epidemiology Unit in the FHS continues to provide ad hoc support to both the CODES Project and IPP's Injury Surveillance System. The Epidemiology Unit in the FHS is also responsible for the Birth Defects Registry.//2008//

Coordination of the development of the Title V Block Grant is supervised by Julianne Konopka, Section Chief of the Health Information Systems and Reporting (HISR) Section in the Planning Branch. It is a collaborative effort between the FHS and the HISR Section on all aspects of the Block Grant Application and Annual Report development. Also under the supervision of Julianne Konopka is the State Office of Vital Records. Epidemiologists within this Section use vital records information to help direct and evaluate Title V program activity and also provide epidemiological support to the FHS and Title V programs.

/2007/The coordination of the development of the MCHBG application will be transitioned to staff in the FHS.//2007//

/2008/FHS staff has taken over the responsibility for coordinating the MCHBG.//2008//

Resumes are included as Supporting Documents and are on file at DPH for Lisa Davis, Marcia Cavacas, Dorothy Pacyna, and Sharon Tarala. DPH Organizational charts are attached to this section and included in the Supporting Documents Section. /2007/Resumes for Barbara Pickett and Vine Samuels are also included.//2007//

/2008/ Resumes are included in one document for Mark Keenan and Janet Brancifort. Agency organizational charts can be accessed at www.dph.state.ct.us//2008//

An attachment is included in this section.

An attachment is included in this section.

D. Other MCH Capacity

The Department is comprised of eight Branches, a new organizational structure as a result of agency-wide focus groups and strategic planning workshops in late 2004 and implemented February 2005. Within the Public Health Initiatives (PHI) Branch, led by Richard Edmonds, MA,

Lisa Davis, RN, BSN, MBA serves as the Director of the Family Health Section (FHS) and as the Title V Director. Robin Lewis provides secretarial support to Ms. Davis. The majority of CT's Title V program activities reside organizationally within the FHS in the PHI Branch. /2007/Ms. Davis was promoted to Section Chief, Family Health Section effective December 2005. //2007//

/2008/ Jackie Douglas now provides secretarial support to Ms. Davis. In addition to functioning as the Title V Director, and Chief for the FHS, Ms. Davis was recently selected to participate in the Robert Wood Johnson Executive Nurse Fellows Program. Participation in this program will help strengthen Ms. Davis' leadership skills. In addition, Ms. Davis is participating in the AMCHP Title V Directors mentor program and is being mentored by Sally Fogerty of the MA DPH.//2008//

Sharon Tarala, RN, JD was recently promoted to Supervising Nurse Consultant and is now responsible for the Women, Men, Aging & Community Health Unit. Staff within this unit include Nurse Consultants Donna Fox, RN, MA, and Anthony Mascia, MSN, RN. Additional staff include Health Program Associates Marilyn Binns, Felicia Epps and Veronica Korn. These staff work on the following programs: Comadrona, Community Health Centers, Family Planning, Fetal and Infant Mortality Review, Healthy Choices for Women and Children, Intimate Partner Violence, MCH Referral and Information Services, Pregnancy Related Mortality Surveillance, Right from the Start, Sexual Assault Prevention and Intervention./2007/Anthony Mascia, Donna Fox, Marilyn Binns, and Veronica Korn no longer work in this unit. Additional staff include Shiu-Yu Kettering, Health Program Associate and Lauren Backman, Epidemiologist 3. Staff in this unit now work on the Healthy Start program and the MCH Referral and Information Services program is now within the and School and Adolescent Health Unit.//2007//

/2008/ this Unit has been renamed to the Primary Care and Prevention Unit. Ms Tarala is the State Women's Health Coordinator. The Primary Care Office grant and activities are housed in this Unit.//2008//

Within the Child, Adolescent and School Health Unit, The CYSHCN program is supervised by Dorothy Pacyna, RN and includes Epidemiologist Chun-Fu Liu, and Health Program Associates Robin Tousey-Ayers and Ann Gionet. Ms. Gionet also serves as a Family Advocate, and works closely with staff to provide support for all areas of the Medical Home System with focus on the respite component, the Regional Family Support Network (RFSN). She also provides consultation to staff regarding family issues, participates in the development and review of appropriate program policies to ensure that a family-centered, culturally competent perspective is maintained. The Newborn Screening program in this unit, led by Vine Samuels, includes Nurse Consultants Fay Larson, RN, MSHA, Donna Maselli, RN, BS, MPH and Dottie Trebisacci, RN as well as Health Program Associate Shi-Yu Kettering and Health Program Assistant Amy Olrongly. The School and Adolescent Health Program in this unit, led by Barbara Pickett, includes Nurse Consultants Donna Heins, RN, CHES, MPH and Regina Owusu, RN, BSN, MPH; Health Program Associate Linda Durante Burns and Nutrition Consultant Charles Slaughter. Rose Marie Mitchell provides secretarial support to the unit. The programs served by this entire unit are: Abstinence Only Education, Expanded School Health Services, School Based Health Centers, Children and Youth with Special Health Care Needs, Genetic Services, Maternal PKU, Pregnancy Exposure Information Services, Sickle Cell Services, Sickle Cell Transition, Universal Newborn Screening (metabolic and hearing). Kevin Sullivan, Health Program Associate, is responsible for coordinating the CT Early Childhood Comprehensive Systems (Early Childhood Partners, ECP) program.

/2007/ The new CYSHCN Unit, led by Dorothy Pacyna, Supervising Nurse Consultant, includes Health Program Associates Ann Gionet, who is part time, and Robin Tousey-Ayers. There is one Health Program Associate position vacant. This unit has been responsible for the implementation of the 5 Regional Medical Home Support Centers. Ms Gionet, the FHS Family Advocate, provides coordination activities related to the Family Support Network protocols and advocacy for families. Ms Tousey-Ayers coordinates activities for the Medical Home Network protocol as well

as coordinating with the A.J. Pappanikou Center, which was responsible for facilitating this year's regional inter-agency workgroups on youth transition. The Health Program Associate position formerly held by Ms Burns would coordinate the utilization of the Extended Service and Respite Funds and DocSite training activities.//2007//

/2008/ The CYSHCN Unit is now under the supervision of Mark Keenan, Supervising Nurse Consultant (Ms. Pacyna retired from state service). In addition to Ms. Tousey-Ayers and Ms. Gionet, the Consumer Information Representative position will be filled by mid-summer. The Newborn Hearing Screening Program is now housed in the CYSHCN Unit.//2008//

/2007/ The Newborn Screening Unit, led by Health Program Supervisor Vine Samuels, BA, MPH, includes Nurse Consultants Fay Larson, RN, MSHA, Donna Maselli, RN, BS, MPH and Dottie Trebisacci, RN as well as Health Program Associate Marilyn Binns and Health Program Assistant 1 Amy Mirizzi. This program consists of Newborn Genetic Screening (Maternal PKU, Sick Cell Services and the Pregnancy Exposure Information Services), the Early Hearing, Detection and Intervention program (EHDI) and the newly established Sick Cell Disease Transition program. Gloria Powell, RN, Nurse Consultant will begin in the NBS program in July.//2007//

/2008/ The metabolic newborn screening program remains under the supervision of Vine Samuels. The Newborn Hearing Screening program has been relocated to the CYSHCN Unit. It is anticipated that by mid-summer the metabolic screening program staff will be relocated to the state laboratory.//2008//

/2007/ The School and Adolescent Health Unit, led by Health Program Supervisor Barbara Pickett, includes Nurse Consultants Donna Heins, RN, CHES, MPH and Regina Owusu, RN, BSN, MPH; Social Worker Meryl Tom, LCSW and Cheryl Poulter, Health Program Assistant Trainee. The programs served by this entire unit are: Abstinence Only Education, Expanded School Health Services, School Based Health Centers, and the MCH Referral and Information Services.//2007//

/2008/ Donna Heins, Nurse Consultant in the SAHU also functions as the State Adolescent Health Coordinator.//2008//

Marcia Cavacas has been promoted to Epidemiologist 4 and serves as the supervisor of the Epidemiology and Injury Prevention Unit. Clerical support is provided by Jacqueline Douglas. Epidemiologists Carol Stone, PhD., and Jennifer Morin, MPH support programs across FHS. Social Worker Meryl Tom and Health Program Associates Marian Storch and Margie Hudson also serve programs in the unit including Child Health Access Project, Statewide Systems Development Initiative (SSDI), Children with Special Health Care Needs Registry, CODES and injury prevention activities. This unit is currently recruiting for two Title V-funded Epidemiologist 2 positions.

/2007/ With the transition of the Injury Prevention Program to another section, this is now known as the Epidemiology Unit. New to this unit in the past year are Chunfu Liu, MS, MPH, Johanna Davis, and Ann Kloter, MPH, who now support programs across FHS. Meryl Tom, Marian Storch and Margie Hudson have relocated along with their programs to other units. The Unit seeks to identify, collect and analyze population-based MCH data, and to create new systems that complement exiting data that will enhance FHS's capacity for programmatic planning, evaluation and surveillance. //2007//

/2008/ The CODES project has been relocated to the Health Education Management and Surveillance (HEMS) Section where the injury prevention program is located//2008//

Dr. Ardell Wilson, DDS, MPH has been designated as the State Oral Health Director and is responsible for the Office of Dental Public Health. Recruitment continues for staffing to support

the activities conducted by this Office. /2007/ Linda Ferraro, RDA has now joined the Office of Dental Public Health as a Health Program Associate.//2007//

/2008/ Staff are collaborating with the Office of Dental Public Health, which has been renamed the Office of Oral Public Health, to submit a HRSA grant application for Perinatal oral health.//2008//

Within the Planning Branch, the Health Information Systems and Reporting Section, support through the preparation of the MCHBG application is provided. Also, Epidemiologists Diane Aye, MPH, PhD, Marijane Mitchell, MS, Celeste Jorge, BA, and Associate Research Analyst Federico Amadeo, MPA provide epidemiologic support to FHS programs and through their work on other programs such as the Connecticut School Health Survey, Health Professional Shortage Areas, and Vital Statistics.

/2008/ FHS has assumed the role of preparing the MCHBG application.//2008//

Within the Administrative Branch, support to Title V programs is given by the Contracts Management Division and Fiscal Services. At the State Public Health Laboratory, Lab Assistant Leslie Mills offers support to the Newborn Screening program.

Resumes are on file at DPH for Lisa Davis, Dorothy Pacyna, Marcia Cavacas, and Sharon Tarala and can be found in the Supporting Documents section.

/2007/ Resumes for Barbara Pickett and Vine Samuels are also included.//2007//

/2008/ Resumes for Mark Keenan and Janet Brancifort are included.//2008//

An attachment is included in this section.

E. State Agency Coordination

CT's Title V Program has established working relationships with the organizations found in the document attached to this section. Because of the diverse programs funded by the Block Grant, DPH works with other state agencies and within its own programs to insure coordination of services. Please see the attachment to this section for a listing of all organizations. The narrative below describes the most important of those collaborations.

Abstinence-Only Education program staff work closely with School Based Health Centers (SBHCs), the CT Association of Schools, and other State and local agencies and organizations affected by the project, including CYSHCN Program, STD Program, AIDS Program, SDE, DSS, DCF, and OPM. Staff coordinate with representatives of Network CT, a SPRANS community-based abstinence education grantee, to share information and resources, including but not limited to peer mentors and counselors, parent/guardian outreach activities, and public awareness activities, such as radio spots, program brochures and posters. ***/2008/The Abstinence program is working with UConn to evaluate its Abstinence Education Program.//2008//***

The CYSHCN program collaborates with the Social Security Administration/Disability Determination Unit at DSS to identify and refer potential enrollees to the Program. CYSHCN program staff also network with the Bureau of Rehabilitation Services at DSS regarding the provision of occupational services to youth transitioning to adulthood.

Staff from DPH and the CYSHCN Regional Centers participate on: DCF Advisory Committee for Medically Fragile Children in Foster Care, DMR's Birth to 3 Public Awareness and Medical Advisory Committee and Interagency Coordinating Council (ICC), and the legislatively mandated Family Support Council. /2007/Staff participate on the DPH Medical Home Advisory Council which provides guidance and advice to DPH in its efforts to improve the system of care for CYSHCN. DPH partnered with the A.J. Pappanikou Center on Developmental Disabilities to coordinate the roles of state agencies in meeting the challenges of care coordination. The

Center also facilitated meetings with community-based organizations on best practices to meet the needs of CYSHCN.//2007//

/2008/ staff participate in the AJ Pappanikou Center's Consumer Advisory Council.//2008//

Memoranda of Understanding are being drafted by DPH with multiple state agencies (DSS, DMR, DCF, SDE). Through these agreements, the parties intend to recognize their shared goals and to establish methods of coordination and cooperation to ensure that CYSHCN and their families/caregivers who are served by the Regional Medical Home Support Centers (RMHSC) receive timely and comprehensive health care services.

/2008/ The MOU was put on hold due to the new direction of the medical home project.//2008//

DPH joined in partnership with United Way of CT/2-1-1 Infoline, DMR (Birth to 3), and the Children's Trust Fund (Help Me Grow) supporting the CDI to serve as the centralized point of entry for all CYSHCN in a system of care. CDI will develop and implement a referral and coordination of services model to assess and refer appropriate CYSHCN to Birth to 3, Ages and Stages, Help Me Grow and a local RMHSC. /2007/DPH contracted with CREC/Soundbridge to implement the Listen & Learn program which provides follow-up of infants identified through the EHDI program who were not eligible for Birth-to-3 services.//2007//

DPH, through its partnership with the CHDI, contracted with AHEC to develop and implement a Medical Home Academy (MHA) for pediatric physicians, nurses, other allied health professionals, and families. The CT MHA was introduced as one full-day Medical Home Implementation Conference on March 8, 2005.

DPH and the CT Lifespan Respite Coalition, Inc. (CLRC) have partnered to create a two-section "Get Creative About Respite" manual. To determine the importance of respite services and provide information to families in the state, DPH conducted a needs assessment and found the top 5 gaps included planned respite, emergency respite, after school programs, summer day camp, and summer overnight camp. DPH contracted with CT Lifespan Respite Coalition, Inc. to provide 8 statewide information sessions on the Get Creative About Respite manual.

/2008/ "Directions: Resources for Your Child's Care" an information organizer for families was made available.//2008//

DPH is working with the Champions for Progress Center housed at the Early Intervention Research Institute at Utah State University for assistance in the production of leadership to accelerate the process of systems building at the state and community levels. The Champions for Progress Center assists with the development of private/public partnerships using a Participatory Action Research Approach (PARA), coordinates State/territory plans and activities with partners around the 6 core measures for CYSHCN.

The Newborn Screening program staff work with the 30 CT birthing facilities, State Laboratory, Audiology Diagnostic Centers, the Regional Treatment Centers and individual medical homes to assure the testing, tracking, and treatment components of the Universal Newborn Screening Hearing and Laboratory Programs.

A Newborn Screening program staff is an active member of the CT Newborn Hearing Screening Task Force. The Task Force members include representatives from the DSS, DMR, birth hospital nurse managers, UConn Division of Family Studies, neonatologists and audiologists. The group meets monthly to plan and coordinate activities across state and other agencies, that promotes optimal outcomes for infants identified with hearing loss.//2007/The EHDI program contracted with the UConn Division of Human Genetics to develop a web based training for pediatric healthcare providers on genetic testing in newborns and partnered with the UConn Communication Disorders Center and the American Speech and Hearing Association to offer continuing education units to audiologists who attend annual training.//2007//

/2008/ The web-based training was launched in April //2008//

Quarterly meetings are held with a Genetic Advisory Committee (GAC), comprised of the Sickle Cell, Genetics and Metabolic specialty treatment centers and Newborn Screening Program staff from the FHS and DPH State Laboratory, as well as a consumer representative from the Citizens for Quality Sickle Cell Care, Inc.

A DPH CT Genetics Stakeholder Advisory Committee was formed to advise the Commissioner on the development of a Genomics Statewide Plan. This committee is comprised of representatives with expertise in genetics, law and bioethics; individuals from industry, insurance and academia; medical providers and genetic counselors; and consumer advocates. /2007/The committee is now known as the CT Expert Genomics Advisory Panel. FHS staff participate on these panels. One serves as co-chair on the Services Workgroup, and another participates on the Sciences Workgroup.//2007//

/2007/In January 2006, a Statewide Sickle Cell Planning group was developed to address transition services for youth and adults with Sickle Cell. The planning group is comprised of advocacy groups, sickle cell associations, hospitals, treatment centers, university students and DPH staff. DPH was approved for MCHB TA for a consultant to develop the comprehensive statewide sickle cell plan.//2007//

/2008/ MCHB TA was utilized to develop a statewide sickle cell plan.//2008//

Health professionals of the DPH Newborn Screening Program and the Regional Treatment Centers participate on various state, regional, and national committees and resource groups such as: the CT PKU Planning Group, NE Mothers Resource Group, New England Consortium of Metabolic Programs, NERGG, Inc., National Newborn Screening Genetic Resource Center, and the National Newborn Screening Advisory Committee. Participation on these committees provides the opportunity to network experts and consumers, participate in educational conferences, and keep abreast of advances in genetics and newborn screening as they impact public health. Program staff participate in the UConn MPH Program and provide NBS educational sessions to students as part of the Genetics course curriculum.

Site Coordinators of SBHCs meet bi-monthly with FHS staff to address grantee issues, training and technical assistance, information and resource sharing and input on overall project direction. CT SBHCs have formed a non-profit independent organization, the CT Association of SBHCs, Inc., to advocate for this service delivery model.

Sixty-three SBHCs in 18 communities are partially funded by DPH serving students in elementary, middle and high schools. SBHCs are licensed as outpatient facilities and staffed by both Advanced Nurse Practitioners and Licensed Social Workers. They offer an array of services addressing the medical, mental and oral health needs of youth, including crisis intervention, health education, social services, outreach, and substance abuse prevention services. Students enrolled in the SBHCs are provided with early periodic screening, diagnosis and treatment (EPSDT). The practitioners coordinate the care they provide with a child's primary and specialist caregivers, while integrating the needs of the child with other school personnel. /2007/There are now 65 SBHCs in 19 communities.//2007//

/2008/ A SBHC Ad Hoc Committee was formed with the goal of improving health care through access to SBHCs, particularly by under- or uninsured people or Medicaid recipients.//2008//

Child, Adolescent and School Health Unit staff are engaged in the interagency steering team of the Coordinated School Health Program. This team is comprised of members from DPH, SDE, and DCF. A Nurse Consultant with DPH's SBHC program is an active member of the State Adolescent Health Coordinator's Network, which is a national association of all state and territorial adolescent health coordinators, and a member of the National Assembly on School Based Health Care. Staff also participate in the Regional Stakeholders Group, with representation from DPH and SDE. The group works to enhance collaboration on issues of HIV, STDs, and

Abstinence.

Within the Women, Men, Aging and Community Health Unit of the FHS, MCH program staff represent DPH on the New Haven Family Alliance, Male Involvement Network, The Community Foundation for Greater New Haven Perinatal Partnership Committee, and DSS's Fatherhood Initiative Council.

//2008 FHS staff will participate on the Advisory Committee for DSS' Responsible Fatherhood Grant.//2008//

In an effort to build and strengthen community collaborations and to provide technical assistance to our community partners, DPH, in collaboration with the United Way of CT/Infoline 211, developed "A Resource Manual Designed to Help CT Communities Develop and Sustain Coalitions." It will complement the MCH Training, "Developing and Sustaining Coalitions" that was conducted in 2004 by The Consultation Center in New Haven.

Community Health Centers (CHCs) provide comprehensive primary and preventive health care and other essential public health services at 39 sites, and many additional sites for health care for the homeless. All centers are located in HPSA and/or Medically Underserved Areas and operate in accordance with Federally Qualified Health Center Guidelines. Approximately 176,894 people were served with 782,000 visits documented in 2004. Patients served within the CHCs are provided with a wide variety of comprehensive services, including EPSDT. The CHCs also work with Family Planning, WIC, SBHCs, Infoline and many community based organizations that provide other health care and social services.//2007/ In 2005-6, Torrington Community Health Center was awarded state funding which is administered through the DPH.//2007// /2008/ In 2005, over 200,000 people sought services, generating nearly 900,000 visits to CHCs//2008//

The statewide family planning program is implemented through a contract with Planned Parenthood of CT in 15 sites (10 Planned Parenthood centers and 5 designated agencies). The services provided include comprehensive preventive and primary reproductive health care for adolescents and adult males and females. During FY 2004, 41,838 clients received services. The program goals and activities include education in a variety of forums for youth, parents, teachers, social workers and clergy. Forums are held in schools, churches, community based social service offices and recreational programs. The prevention focus includes the prevention of pregnancy (including abstinence education), STIs, Hepatitis and HIV/AIDS. /2007/A new Planned Parenthood site was added in Danbury.//2007//
/2008/ Planned Parenthood of CT has 16 sites and during FY 06, 33,669 clients received services.//2008//

All DPH-funded community health centers in CT are members of the CT Primary Care Association (CPCA). DPH and CPCA work together on a number of important initiatives to promote, inform policy, and develop community based systems of care for the state's most vulnerable populations and to support CHCs. Among these are the CT River Valley Farmworker Health Program (in conjunction with the Massachusetts League of CHCs), National Health Service Corps recruitment and retention activities, immunization program initiatives, breast and cervical cancer screening, domestic violence prevention and homelessness. ***/2008/ DPH contracted with two CHCs to pilot a perinatal depression screening tool.//2008//***

In collaboration with CPCA, a Healthcare for the Homeless Advisory Board was established and a conference was held to strengthen links between healthcare providers and shelters. A needs assessment of homeless persons in CT and a strategic plan to improve the health status of CT's homeless men, women and children was conducted. The Advisory Board is in the process of implementing activities identified in the strategic plan. Mini-grants were provided to 10 CHCs to better address and link homeless persons in their communities with primary health care services.

DPH partnered with AHEC to co-fund and implement the CT Youth Health Service Corp (CYHSC) with a purpose of promoting teen pregnancy prevention by engaging youth in activities that promote healthy behaviors and lifestyles and support workforce development by facilitating the transition of youth from school to employment in the health care field, particularly with underserved populations. A curriculum was developed that provided students with information on confidentiality/HIPPA, Homelessness 101, Ethical and Legal Issues and Applied Health Services.

//2008/ Although this program continues to operate, DPH no longer funds the CYHSC through the PCO grant.//2008//

The DPH participates on the CT Breastfeeding Coalition (CBC), which includes representatives from the state and local WIC program, La Leche League, AAP, Hospitals, CHCs, HMOs, Universities, independent Lactation Consultants, Medela Corporation and consumers. The Coalition meets on a monthly basis and has 4 active committees: Policy and Advocacy, Data, Provider Education, and Public Awareness. The goals of CBC are to increase public awareness and support for breastfeeding statewide and promote breastfeeding as the social norm. In May 2005, in collaboration with the DPH, the CBC sponsored a symposium attended by over 100 health care providers, which focused on the integration of breastfeeding support in office practices. The FHS continues to work closely with the WIC program to promote and support breastfeeding in the state.***//2008/ The goals of the CBC have been revised to a mission to improve CT's health by working collaboratively to protect, promote & support breastfeeding.//2008//***

As part of the Women's Health Initiative, DPH staff actively participates in the Office of Women's Health Region 1 Workgroup to increase the focus on women's health, foster collaboration, and encourage the development of women's health activities in the state and in the New England region. The DPH convened a collaborative workgroup, "Going Home Healthy," at York Correctional Institute, the State's only female correctional facility, with the purpose of transitioning women back into the community healthy. The workgroup is comprised of representatives from various state and community-based agencies and has developed a community-specific resource guide and gender-specific discharge cards for soon to-be released inmates. In addition, DPH funded contractors have been invited to participate in the on-site "community days" so that inmates have a better understanding of where and how to access health and social services in their particular community of discharge.***//2008/DPH will execute an MOA with the DOC & UConn to facilitate activities & training regarding Intimate Partner Violence for inmates and staff at the YCI. DPH has formed a partnership with the Hartford Community Court & the DSS to work with adolescent fathers.//2008//***

During National Women's Health week, DPH collaborated with the CT Sexual Assault Crisis Services (ConnSacs) and other DPH initiatives to raise awareness about sexual assault prevention, nutrition, cardiovascular disease and HIV/AIDS. Community based forums that addressed these topics were conducted in New Haven, Bridgeport, Hartford and at a shopping mall.***//2008/ During National Women's Health Week, DPH provided health screenings (blood pressure, BMI, etc) to state employees.//2008//***

Facilitated by Central AHEC, DPH convened the statewide perinatal advisory committee. The purpose of this committee was to develop a comprehensive, statewide plan to address perinatal health services in CT. Representation on the committee included: the State Agencies DPH, DSS, DCF, DMHAS, and also the New Haven Health Department, New Haven Healthy Start, The CT

Hospital Association, CT Women's Consortium, CT Chapter of the March of Dimes, Real Dads Forever, Planned Parenthood of CT, CPCA, Permanent Status on the Commission of Women, AAP, UConn Department of Neonatal and Perinatal Medicine, UConn Department of Obstetrics and Gynecology, and the CT State Medical Society. The Advisory Committee identified 9 goals and objectives to address the perinatal health needs in CT.

/2007/ The Perinatal Depression Workgroup is comprised of representatives from the DPH, DMHAS, DSS, Local Health Departments, CT Chapters of the AAP, ACOG, Nurse Midwives, and March of Dimes, United Way of CT/ Infoline, Yale University, UConn, CT Women's Consortium, PCSW, CPCA, CHCs, Office of Rural Health, and consumers. A statewide summit was convened in May 2006 and the perinatal depression campaign (print and media) will be launched in the summer. //2007//

/2008/ The Perinatal Advisory Committee will be integrated with the recently reconvened Infoline MCH Advisory Committee. The Perinatal Depression Workgroup remains active.//2008//

CT's Healthy Mothers/Healthy Babies Coalition is jointly chaired by a staff member within the FHS and the CT Chapter of the March of Dimes. The mission of the Coalition is to promote the health and well being of women and children in CT through leadership, collaboration, and resource sharing.

Within the Surveillance, Evaluation, and Quality Assurance Unit (SEQA) of FHS, staff has worked to establish the CT Birth Defects Registry and work closely with birthing units within the hospitals of the state. A web-based reporting system for the CYSHCN is used by medical homes and Regional Medical Home Support Centers (RMHSC), and is linked to the registry at DPH. Infoline is working with DPH and has become the single entry-point of CYSHCN for referrals to the Birth to 3 Program and the RMHSC for needed services.

SEQA staff represent DPH on the steering committee for Early Childhood Data CONNECTIONs, a public-private partnership of DSS and CHDI to bring together stakeholders to address the needs for better information on key early childhood indicators. The goal is to further build the capacity of state government to collect, analyze and report key information on the needs and services for young children (birth to age 8) and to develop and facilitate a research agenda for advancing early childhood public policy through partnerships.

The MOU between DPH and DSS regarding data exchange exists to improve public health service delivery outcomes for low-income populations through the sharing of available Medicaid, HUSKY Part B and Plus, and Title V data. The initial MOU addresses the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and data on Children Receiving Title V Services and Medicaid data.

/2008/ The first addendum of the Data Sharing MOU related to the linkage of birth & Medicaid data was amended to include a linkage to clients under the fee-for-service component of Medicaid. //2008//

SEQA staff act as the state identified data contact for the Office of Women's Health Region 1 database project. Staff has facilitated the collection of the health status information needed for this database and coordinated the subsequent in-state training for use of this database.

/2008/ FH Epidemiology staff continue to coordinate the provision of data to the OWH Region 1 database.//2008//

DPH has worked with the Office of the Governor through the Governor's Collaboration for Young Children to establish The Healthy Child Care CT initiative. Its goal is to achieve optimal health and development for all children in childcare by guiding and supporting service integration between the childcare community and health care providers. DPH participates on the 5-member Leadership Team that guides the Healthy Child Care CT, along with the executive director of the Children's Health Council. The team has established a regional Core Committee representing

organizations that play a key role in the planning and delivery of childcare and health care for children and their families. Healthy Child Care CT also works closely with the national Healthy Child Care America campaign, which is coordinated by the AAP with support from the DHHS Child Care and MCH Bureaus. As part of the Healthy Child Care CT initiative, DPH collaborated with staff from DSS, Yale University School of Nursing, UConn Stamford, and Southern CT State University to conduct a 6-day training program for Day Care Health Consultants, Education Consultants and Directors of Day Care Facilities. This program addressed many aspects relating to the health and safety of children in day care facilities.

The CT Coalition to Stop Underage Drinking, designed to curb under age drinking, involves all state agencies and advocacy groups across the state. The coalition is headed by the Governor's Partnership Project, Drugs Don't Work! and is funded by the RWJ Foundation.

CT does not function on a county-based system for the delivery of public health services to its residents. However, the Commissioner of DPH, through the Local Health Administration Branch, assists and advises local health districts in the state as they play a critical role in planning, providing, and advocating for public health services on the local level. The services provided include prenatal and family planning clinics, child health clinics, nutrition services, immunizations, communicable disease surveillance and control, HIV counseling and testing and other services. DPH's Local Health Branch administers state funding for local health departments and districts.

The Early Childhood Partners Initiative established a steering team and developed a memorandum of agreement with the Commission on Children to co-sponsor a roundtable on shared outcomes. The ECP process brought together 8 State agencies and statewide institutions, and the community to create a performance-based, outcome-driven Strategic Plan to support all CT families so their children arrive at school healthy and ready to learn. /2007/ The ECP Steering Committee was expanded and convened. The DPH's Deputy Commissioner has been appointed to the new Governor's Early Childhood Education Cabinet. The purpose of the Cabinet is to develop a strategic plan to assure that children enter kindergarten fully ready for school success //2007//

/2008/ Plans are underway to better integrate the goals of the ECP plan into that of the ECE Cabinet.//2008//

To address intentional and unintentional injuries, DPH staff collaborate with the CT DOT, SDE, DCF, DSS, OCA, CSSD, and other public, private, and community-based organizations. State and local SAFE KIDS Coalitions (membership includes health care, EMS, Police, Fire and community service providers) address motor vehicle injuries. DPH facilitates the CT Young Worker Safety Team, a collaboration that includes the CT and US Departments of Labor and the CT SDE. The group promotes awareness and training to decrease adolescent work related injuries. DPH facilitates the Interagency Suicide Prevention Network, an interagency, interdisciplinary collaboration that has completed a statewide, comprehensive suicide plan. DPH also works with collaborators to address violence prevention, domestic violence and child maltreatment. DPH staff participates in the Northeast Injury Prevention Network, which includes State Health Injury Prevention Programs from Regions I and II, University Injury Research Centers and representatives from Federal Regional Offices. The Network collaborates on injury prevention initiatives of relevance to both the region and the individual states.

/2008/ An MOA between DPH & UCONN was executed to develop a statewide surveillance system to identify the health related issues regarding fetal and infant mortality.//2008//

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Indicator	36.2	40.2	40.2	32.0	
Numerator	662	658	658	676	
Denominator	183107	163615	163615	211036	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2006

2006 data not available at this time.

Notes - 2005

Source: CY2005 OHCA data provided by CTDPH, Planning Branch, 2005 population estimates provided by Backus & Mueller, OHCQSAR.

Notes - 2004

Data provided by CHIME for 2002. Data for 2003 has been requested, not yet received.

Narrative:

Notes -2005

2005 data provided by OHCA and pop'n from OHCQAR.

Notes -2004

Data provided by CHIME for 2002. Data for 2003 has been requested, not yet received.

Notes -2003

Source: CY2000 CT Hospital Association, CHIME program

Narrative:

The rate of hospitalization with a primary diagnosis of asthma has decreased in CY2005. This is a positive in that the trend was increasing since reporting as part of the MCHBG began in 1998.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Indicator	80.2	84.6	85.3	87.9	86.2
Numerator	12155	13108	13475	14386	14429
Denominator	15163	15497	15795	16369	16739
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

Source: CT Dept of Social Services, 2006 CMS 416.

Notes - 2005

Source: CT Dept of Social Services, Form CMS 416, FY2005.

Notes - 2004

CT Dept of Social Services, Form CMS 416, 2004

Narrative:

Notes -2005

Source: CT Dept of Social Services, Form CMS 416, FY2005.

Notes -2004

CT Dept of Social Services, Form CMS 416, 2004

Notes -2003

Source: CT Dept of Social Services, Form CMS 416, FY2003

Narrative:

The percent of Medicaid children less than one who received at least one initial periodic screen decreased slightly from CY 2005, from 87.9% to 86.2% in CY2006. This is a change in the direction of the trend that had been on the increase in previous years. It should be noted however that the actual number of children served through the Medicaid program over this time period has continued to increase.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Indicator	80.2	74.6	79.4	81.0	73.7
Numerator	210	403	377	482	365
Denominator	262	540	475	595	495
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006

Source: CT Dept of Social Services, SFY2006 HUSKY participation report.

Notes - 2005

CT Dept of Social Services, HUSKY B Annual Reports submitted by MCO's, SFY2005.

Notes - 2004

Source: CT Dept of Social Services, HUSKY B Participation Report, SFY04.

Narrative:

Notes - 2005

CT Dept of Social Services, HUSKY B Annual Reports submitted by MCO's, SFY2005.

Notes - 2004

Source: CT Dept of Social Services, HUSKY B Participation Report, SFY04.

Notes - 2003

Source: CT Dept of Social Services, HUSKY B Participation Report, SFY03.

Narrative:

The percents reported for SCHIP enrolled infants served over time show an erratic pattern of increases and decreases. In 2004 approximately 79.4% of HUSKY infants less than one received at least one initial periodic screen representing an increase from 74.6% reported in 2003. In past years through CY 2005, the actual number of infants screened has shown a clear trend of constant improvement with the exception now with the CY 2006 figure indicating a slight decline.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Indicator	84.6	84.3	80.7	80.2	
Numerator	34021	34977	32962	32773	
Denominator	40213	41467	40841	40885	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2006

2006 data not available at this time.

Notes - 2005

Source: CT Dept of Public Health, provisional 2005, Vital Statistics.

Notes - 2004

Source: CT Dept of Public Health, Vital Statistics, CY2004. Provisional Vital Stats (denominator was reduced by unknowns)

Narrative:

Notes - 2005

Source: CT Dept of Public Health, Vital Statistics, CY2005. Provisional Vital Stats (denominator

was reduced by unknowns)

Notes - 2004

Source: CT Dept of Public Health, Vital Statistics, CY2004

Notes - 2003

Source: CT Dept of Public Health, Vital Statistics, CY2002

Narrative:

Approximately 80.2% of women (15 through 44) with a live birth in 2005 received prenatal care scoring at least 80 percent as measured by the Kotelchuck Index. This was a slight decrease from 80.7% of women with a live birth in 2004. Further analysis would be required to determine whether there were significant variations within this cohort of women based on age, race, health insurance or other factors. Appropriate programmatic interventions could then be tailored to the problems identified. National Performance Measure #18 reports that in 2005, 88.9% of women in CT began prenatal care in the first trimester.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Indicator	43.1	44.2	46.9	47.9	59.5
Numerator	101043	111992	121521	129346	123136
Denominator	234466	253576	258978	269941	206831
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006

Source: CT Dept of Social Services, 2006 CMS 416.

Notes - 2005

Source: CT Dept of Social Services, CMS 416, CY05

Notes - 2004

CT Dept of Social Services, Form CMS416, FFY2004.

Narrative:

Notes - 2005

Source: CT Dept of Social Services, CMS 416, CY05

Notes - 2004

CT Dept of Social Services, Form CMS416, FFY2004.

Notes - 2003

CT Dept of Social Services, Form CMS416, FFY2003.

Narrative:

The rate for potentially Medicaid eligible children who received a service paid by the Medicaid program increased from since 2001 from 40.1% to 59.5% percent in 2006. This increase is considered significant in light of decreased emphasis on outreach and enrollment by the Department of Social Services (DSS) that had been secondary to the state budget crisis. While there has been a slight decrease in the number of children being served in CY 2006, the overall trend in previous years has been an increasing one. A number of Title V and non-Title V programs direct their infrastructure building activities to children and adolescents to improve access and utilization of health care.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Indicator	39.7	45.4	46.5	43.7	59.5
Numerator	20144	24073	25099	24689	123136
Denominator	50741	52981	53922	56549	206831
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006

Source: CT Dept of Social Services, 2006 CMS 416.

Notes - 2005

Source: CT Dept of Social Services, Form CMS 416, 2005

Notes - 2004

CT Dept of Social Services, Form CMS 416, 2004

Narrative:

Notes - 2005

Source: CT Dept of Social Services, Form CMS 416, 2005

Notes - 2004

CT Dept of Social Services, Form CMS 416, 2004

Notes - 2003

Source: CT Dept of Social Services, Form CMS 416, FY2003

Narrative:

The percent of EPSDT eligible children age 6 through 9 years who have received any dental services during 2006 was 48.0%. The actual numbers receiving dental services jumped from a low of 16,309 in 2000 to 26,804 in 2006, a 64% increase in children age 6 through 9 who have received any EPSDT dental services during the year. While this is a welcome increase, provision/availability of dental services remains an important need in Connecticut especially among the poor and uninsured. Connecticut's OPENWIDE program has made progress in

increasing the ability of non-dental health professionals to make appropriate referrals for dental care.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Indicator	7.3	7.3	3.6	3.6	
Numerator	382	396	76	47	
Denominator	5220	5419	2120	1296	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2006

2006 data not available.

Notes - 2005

Source: CT Dept of Public Health, CYSHCN Program, estimate based on one quarter's data ending 12/05. (Federal and state database are currently in transition.)

Notes - 2004

Source: CCY05 CSHCN Program' DocSite database for numerator with partial year SSI data as the denominator.

Narrative:

Notes - 2005

No data available.

Notes - 2004

Source: CCY05 CSHCN Program' DocSite database for numerator with partial year SSI data as the denominator.

Notes - 2003

Source: US Social Security Administration SORD File 100% data, CY2002-3 for denominator. Numerator data estimated based on 2001 percent experienced with old methodology. CSHCN program is in a transition phase to regional medical home models. Data systems will be built into these new programs effecting a new methodology for capturing this information.

Narrative:

In 2005, only an estimated figure was available for this measure. The CYSHCN Program data collection process was in a transition phase during this year. However, the estimate of SSI beneficiaries receiving CSHCN services in CY 2005 remained level with the 3.6% reported in CY 2004.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2004	matching data files	9.6	7.2	7.8

Notes - 2008

Medicaid-specific reporting in this form used CY 2004 data from matching files.

Note: This will not match more recent data i.e. CY2005 statistics reported elsewhere in the TVIS.

Narrative:

Notes - 2007

Source: The most recent DSS data file available for matching was 2002 even though 2004 Vital Stats are reported elsewhere for CT.

Narrative:

For the 2004 birth cohort year there was a match of Medicaid records and Vital Records completed by a sub-contractor under agreement with the Department of Social Services (DSS) and the DPH. Data are presented for that year in the columns headed "Medicaid" and "Non-Medicaid." DPH has worked with DSS in establishing a Memorandum of Understanding with the goal of ensuring that this record match be available every year.

The column labeled "All" contains Vital Records information for 2004 for the entire state population. A more detailed look at this data by race and ethnicity is available in the attachment to the Overview section of this report, Table 4. Approximately 84.6% of women (15 through 44) with a live birth in 2003 received prenatal care scoring at least 80 percent as measured by the Kotelchuck Index.

For all four indicators the Medicaid population shows poorer outcomes than the Non-Medicaid population. HSCI#05a: 9.6% of the deliveries paid for by Medicaid were low birth weight babies in comparison to the Non-Medicaid population's experience of 7.2% low birth weight.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2004	matching data files	6.9	4.2	4.9

Notes - 2008

Medicaid-specific reporting in this form used CY 2004 data from matching files.

Note: This will not match more recent data i.e. CY2005 statistics reported elsewhere in the TVIS.

Narrative:

Notes - 2007

Source: The most recent DSS data file available for matching ws 2002 even though 2004 Vital Stats are reported elsewhere for CT.

Narrative:

For HSCI #5B, the rate of infant deaths per 1,000 live births was higher for the Medicaid population, at 6.9% compared to Non-Medicaid rate of 4.2%.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2004	matching data files	77.5	90.4	85.9

Notes - 2008

Medicaid-specific reporting in this form used CY 2004 data from matching files.

Note: This will not match more recent data i.e. CY2005 statistics reported elsewhere in the TVIS.

Narrative:

Notes - 2007

Source: The most recent DSS data file available for matching was 2002 even though 2004 Vital Stats are reported elsewhere for CT

Narrative:

For HSCI#05c, Medicaid mothers were less likely to receive prenatal care beginning in the first trimester (77.5% Medicaid versus 90.4 % for the Non-Medicaid population).

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to	2004	matching data files	74	82.7	80.6

expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					
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Notes - 2008

Medicaid-specific reporting in this form used CY 2004 data from matching files.

Note: This will not match more recent data i.e. CY2005 statistics reported elsewhere in the TVIS.

Narrative:

Notes - 2007

Source: The most recent DSS data file available for matching was 2002 even though 2004 Vital Stats are reported elsewhere for CT

Narrative:

Similarly HSCI#05d reports that the Medicaid population's prenatal care Kotelchuck score was worse than the Non-Medicaid women's experience (74.0% Medicaid versus 82.7 % Non-Medicaid population).

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2006	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2006	300

Notes - 2008

Source: CT Dept of Social Services, May 2006

Narrative:

Notes - 2007

Source: CT DSS 2005

Narrative:

Infants, Children up to age 16, and Pregnant Women are eligible for Medicaid if the family income is less than 185 percent of the poverty level.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 16) (Age range to)	2006	185

(Age range to)		
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2006	300

Notes - 2008

Source: CT Dept of Social Services, May 2006

Narrative:

Notes - 2007

Source: CT DSS 2005

Narrative:

Infants, Children up to age 19, and Pregnant Women are eligible for SCHIP or HUSKY if the family income is less than 300 percent of the poverty level

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2006	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2006	300

Notes - 2008

Source: CT Dept of Social Services, May 2006

Notes - 2008

SCHIP would cover pregnant teenagers 2006.

Narrative:

Narrative:

In Connecticut, pregnant women are not covered by this program.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
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<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2008

Narrative:

Narrative:

The improvement in this indicator was the implementation of the Birth Defects Registry. Work is beginning toward obtaining annual WIC eligibility but will not be in place until next year. CT will continue to apply for a CDC PRAMS grant as it becomes available. DPH has continued to seek funding to conduct a PRAMS-like survey, PRATS in lieu of PRAMS.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2008

Narrative:

Narrative:

Connecticut uses data from the Youth Risk Behavior Survey (YRBS) as a source of youth tobacco use information. Data from the YRBS conducted in 2005 indicates that 2003 indicates that 18.1% of high school students surveyed have smoked a cigarette within the past 30 days.

This was a significant difference from the national rate of 23.0%, and a decrease from 35.2% in 1997. In 2005 the DPH partnered with SDE in the administration of a joint YRBS/Youth Tobacco Survey (YTS) to a sample of CT school children under the new name of CT School Health Survey.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The priority needs presented in the next section were identified through a comprehensive needs assessment during August 2004 through May 2005, to identify state MCH priorities, to arrange programmatic and policy activity around these priorities, and to develop state performance measures to monitor the success of their efforts. The MCH needs assessment was designed to be population-based, community-focused, and framed within a family context.

The MCH Director established an MCH Needs Assessment Planning Committee to assist in the oversight and direction of the needs assessment. The Planning Committee included staff from the various MCH programs, staff from the Health Information Systems and Reporting Section, and staff from the Health Education, Management, and Surveillance Section.

In order to include key stakeholders in a meaningful and integral part of the needs assessment, DPH staff identified and convened an initial collaborative meeting with many invited state agencies and community and professional organizations. The MCH Director presented an overview of the MCH Block Grant and the required five-year needs assessment at the initial collaborative meeting. This collaborative group, which met several times over a six-month period, also provided oversight of the community centered needs assessment.

The Planning Committee also determined that the needs assessment process would include two components: 1) DPH Internal Needs Assessment, and 2) Community Centered Needs Assessment. The DPH Internal Needs Assessment process gathered data and reports housed at DPH, interpreted the data for programmatic implications, and recommended 7-10 state priority needs. The Community Centered Needs Assessment process identified community level data and reports, and all methods of collecting community data. This provided a forum for community input into the determination of the state priority needs.

Each Internal Needs Assessment workgroup was instructed to recommend 5 priority needs for a total of 15 priority needs to be considered by the DPH Planning Committee. It was part of the Planning Committee's charge to reduce the recommended 15 priority needs to 7-10 state priority needs. The Planning Committee, after much discussion and consideration, drafted a set of state priority needs, which were subsequently considered along with those identified by the Community Centered Needs Assessment.

In the Community Centered Needs Assessment, both qualitative and quantitative methods were used to inform the comprehensive needs assessment process. A health profile was developed for target populations including women, pregnant women, children, adolescents and children with special health care needs (CYSHCN). Additional feedback on the health needs of women and children was obtained from providers and consumers. Engaging the various stakeholder groups facilitated the inclusion of their insights and experience of their practical experiences and served as a valuable reality check. A concerted effort was made to engage providers, advocates and consumers in both identifying priority needs and successful solutions to identified problems.

The Planning Committee met in late May 2005, to review the identified priority needs from the Internal and Community Centered Needs assessment components to assure that the three population groups were appropriately included and establish measurable State Performance Measures. The MCH program selected seven priority needs from the list of potential areas for improving maternal and child health. Criteria used to select top priorities include the likelihood that the intervention will result in improved maternal and child health outcomes, the feasibility of success, and alignment with federal MCH priorities. The DPH Planning Committee added an eighth priority need regarding health disparities as it was deemed a repeated imperative need across the MCH population. The DPH Planning Committee also added a ninth priority need as part of the collaborative work of the federal Region I states to "measure the collective assets of

their childhood health systems."

/2007/ This measure was further developed by Region 1 Title V directors to measure the percentage of licensed child care centers serving children age birth to five who have onsite health consultation.//2007//

/2008/ During the 2006-07 grant year, FHS staff had in-depth conversations with Day Care Licensing staff to discuss the actual available data from the CT Day Care Health Consultant database. In light of the fact that the database was not able to report whether a center had been visited at least once a month by a licensed health care consultant, we updated the language to reflect information that can be obtained from the database with the resulting new SPM language: "The percent of licensed child day care centers serving preschool age children that have reported having contracts with the required four consultants (health, dental, educational and social service) to conduct the required site visits, and to ensure that the health, dental and social service consultants' licenses are current."//2008//

The nine identified State Priority Needs are similar in many ways to those identified 5 years ago. The similarities include the need to address data capacity issues, reduce injuries to children and adolescents, improve child adolescent health status with an added focus on overweight/obesity, enhance CYSHCN services especially family support services, increase access to health care for women and children, and reduce the health disparities that continue to exist specifically in the areas of teen pregnancy, low birth weight, prenatal care, breastfeeding, and infant mortality. One change was the removal of the priority need related to asthma diagnosis and management, as DPH has enhanced its capacity to more effectively address this issue through the now well-established DPH Asthma Program. Another change was the inclusion of the need to address asset-based measurement efforts among the federal Region I states.

B. State Priorities

Through the Needs Assessment process completed for the 2006 Application, DPH identified nine areas of priority needs. These nine areas and how they relate to the National and State Performance Measures, and the capacity and resource capability of the Title V program are described below.

1. Strengthen Data Collection and Reporting

Effective decision-making requires timely and useful data on maternal and child health. One strategy that DPH implemented was the creation of the Virtual Children's Health Bureau (VCHB) in the fall 2004, whose charge was to remove barriers to the effective and efficient sharing of data across sections of the agency to fully maximize the use of child health information. The resulting commitment from DPH staff and executive leadership was the creation of a data warehouse of high-quality linked child health data, which has been titled HIP-Kids (Health Informatics Profile for CT Kids).

The information from HIP-Kids will be an important data source to enhance the DPH's ability to report on performance measures, as well as other required outcome measures. It also will support the goal outlined in the Health Systems Capacity Indicator #9A "the ability of states to assure that the MCH Program and Title V agency have access to policy and program information and data."

This priority need is somewhat related to HP2010 23-11: (Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

The SPM #1, to create HIP-Kids, will support interdivisional public health research activities and initiatives. A broadly accessible data system will enhance the capacity to conduct public health assurance and assessment activities within Connecticut, and will also inform public health policy. Some enhanced essential activities that are anticipated include reducing health disparities among childhood disease prevention activities through better outreach to "hard to reach" populations; increasing ability to evaluate population-based health activities within DPH; improving data quality through better data validation and coordinated data improvement efforts; and enhancing comprehensive data accessibility to support grant activities and health programming.

/2008/ The creation of HIP-Kids fit well with EPHT's goal to develop and modify systems that meet the Public Health Information Network (PHIN), National EPHT Network, & the Environmental Protection Agency's (EPA) Environmental Exchange Network requirements. The data warehouse will collect data from a variety of existing sources, with enhancements to the collection processes for some of that data, & make it available to the DPH to support their query, extraction, & reporting needs./2008//

2. Establish Collaborative Relations at the State/Local Level

The MCH Program acknowledges that improving the health and well-being of women and children requires a collaborative response from state agencies and community providers. For this reason, the MCH Program proposes to enhance and establish formal processes to collaborate with state and local stakeholders committed to improving the health of women and children. Specific issues best addressed through collaborations with state and local partners include increasing access to needed services such as mental health, oral health, specialty care and health services in rural communities, and expanding access to health insurance for low income populations.

While there are no specific National Performance Measures (NPMs) that directly relate to this priority need, the NPMs seek to improve the health of women and children, and many NPMs can only be achieved by collaborating with other state agencies. Similarly, there are no HP2010 objectives that specifically discuss fostering and implementing collaborations with state and local stakeholders, however there are numerous HP2010 objectives relating to the overarching goal to improve the health of women and children (refer to Form 16).

/2008/ FHS Staff are working with the DOC to implement a gender responsive curriculum for both DOC staff and inmates at YCI. An MOA between DPH and UCONN was executed to develop a statewide fetal and infant mortality surveillance system./2008//

3. Reduce Intentional Injuries

The increase in violence and intentional injuries poses a serious public health threat to the adolescent population. Participation in fights is one marker of violent behavior that often results in serious injuries. Efforts to decrease violent behavior will help reduce intentional injuries to adolescents.

The single NPM most closely related to this priority need is #16, the rate of suicide deaths among youths. The selection of this priority need and the related SPM to reduce the number of injuries to adolescents in grades 9-12 due to violence and intentional injury, was purposely identified as part of an early intervention and prevention concept with the intent to address the tendencies to violent and injurious behaviors at an earlier stage. There are three HP2010 objectives that were cited related to this priority need from the Injury and Violence Prevention Chapter of the HP2010 document (see Form 16).

There are several Title V programs (e.g., CHCs and SBHCs) that already address this priority need through education and prevention programs, as well as specific programs like anti-bullying campaigns.

/2008/ FHS provides support to the IPP for the developing Injury Surveillance System & its related grant requirements, including obtaining in-patient hospitalization & ED data from

the CT Hospital Association.//2008//

4. Improve Adolescent Health Status

Adolescents of diverse racial, ethnic backgrounds and those of low socio-economic status who live in very rural sections of the state are at especially high risk for mental health, substance abuse and unintentional injuries. They need easy access to age-appropriate services and are often under-served due to the gap between pediatric and adult medical care services. SBHCs are reaching a number of adolescents but are only available at some schools and not in others. In addition, there is a sub-population of adolescents who are not reached because they are not in school due to dropping out, being incarcerated or are migrant workers.

While there is no specific NPM to address the increase in access to age-appropriate services for adolescents 10-20 years, HP2010 1-4b addresses this priority need with the goal to increase the proportion of persons who have a specific source of ongoing care (Children and youth aged 17 years and under). The HP2010 objective states that, "Young children and elderly adults, aged 65 years and older, are most likely to have a usual source of care, and adults aged 18 to 64 years are least likely. Young adults aged 18 to 24 years are the least likely of any age group to have a usual source of care."

The availability of age-appropriate services for adolescents through the SBHCs has been a positive model in which there has been moderate increased capacity to serve adolescents. The new SPM #4 related to this priority need will seek to further increase this capacity.

/2008/ A legislatively mandated SBHC Ad Hoc Committee was formed with the goals of improving health care through access to school-based health centers (SBHCs). //2008//

5. Promote Nutrition and Exercise to Reduce Obesity

Obesity and its consequences is now the top emerging public health issue in the state. Its importance as a priority health issue stems from it being a preventable condition that is increasing across all major public health population groups, and that it is linked to health problems such as heart disease and Type II diabetes. Obesity is an ideal health issue for community wide action that addresses all aspects of its prevalence among the MCH population.

While there is no NPM that addresses obesity/overweight directly, the new Health System Capacity Indicator #9C seeks to measure whether States have the ability to determine the percent of children who are obese or overweight. CT should be able to obtain percentages from the 2007 and 2009 CT School Health Survey (with a YRBS component) to determine this percentage. As a complimentary approach, the SPM developed for this priority need was focused on the reduction of overweight/obesity in the child and adolescent population with the increase in the number of public schools using educational programs to reduce obesity through physical exercise and nutrition education. /2007/ As part of the new 2007 Guidance, there is now an NPM (# 14) which addresses obesity and overweight in young children. //2007//

There are several HP2010 objectives that were cited related to this priority need (see Form 16).

The capacity for the State to address this priority need will be possible through a formal collaboration with the Department of Education (see new SPM #2) to promote culturally appropriate physical activity and nutrition in schools. This would be especially possible through the Coordinated School Health Model. /2007/ DPH is pursuing the use of the School Health Program Report Card that will be administered by SDE which is based on CDC's School Health Policies and Programs Survey (SHPPS). The SDE is planning to implement the survey to obtain the data for the Report Card in April 2006 from all public schools, and annually thereafter.//2007//
/2008/ DPH was successful in obtaining the survey data from the SDE's School Health Program Report Card & will use these data to report on this SPM. //2008//

6. Increase Access to Pre-conception Education and Parenting

Overall Connecticut's families and children fare well compared to their national counterparts with respect to key national indicators of maternal and child health. Birth rates in Connecticut are lower than national rates; there are proportionally fewer pre-term births; and there are smaller percentages of low birth weight babies. Connecticut children overall are also more likely to receive primary care services, including dental care and other routine and preventive services.

However, there are great disparities in many of the key health indicators between certain segments of the state's population, particularly between teens and adult populations and White (non-Hispanic) majority and minority populations. The causes of some of these disparities are linked to poverty, racism, and other societal problems but many of the disparities are also clearly linked to lack of proper pre-conception education, parent education, and other parenting supports. Young and inexperienced parents, as well as parents with limited knowledge of healthy behaviors and habits, need to have better access to formal, quality pre-conception and parenting education programs.

This priority need directly relates to NPM 18, with a focus on the women under age 20 years, since it was identified that the teen population was a disparate group needing particular attention, as well as race and ethnic disparities. There were three HP2010 objectives identified from the Maternal, Infant and Child Health chapter (see Form 16).

CT could address this priority need by: identifying and promoting the development of quality pre-conception and parent education programs, particularly in the schools and in areas where there are high rates of teen births; developing and disseminating culturally appropriate educational materials and curricula geared to teens and young adults; tracking the number of teens and young adults who receive quality pre-conception and parent education in schools and in other community settings; and promoting provider training and education programs geared to encouraging brief pre-conception counseling and parenting education and referral to community-based educational programs.

//2008/ DPH is partnering with the HHD on their CDC/CityMatCH TA grant to address preconception care. An RFP will be issued for case management services for pregnant women (and teens) in July 2007. This new program is expected to include parenting classes.//2008//

7. Promote access to family support services including respite care and medical home system of care for Children and Youth with Special Health Care Needs

According to data collected by the SLAITS survey there could be as many as 118,000 children with special health care needs living in CT. A number of agencies in the State assist CYSHCN and their families by providing and facilitating family support services including respite care. The two major agencies are DPH and the Department of Mental Retardation (DMR). Great strides have been made to identify and serve families with CYSHCN in the state, particularly families with young children but there are still many families who struggle and efforts need to be made to: 1) improve access to family support and respite care, 2) increase the overall service capacity and the resources available for home and respite care, and 3) support families who have trouble identifying respite providers.

This priority need has three NPMs that relate to the need to increase access to family support services including respite care and the medical home system of care for CYSHCN (NPM #2, #3 and #5). This SPM was developed with the particular focus on assuring that families have access to respite services and the new medical home system of care. There were 3 HP2010 objectives identified related to this priority need (see Form 16) including that have a focus on medical home and service systems for CSHCN.

To address this priority need, the State will use the newly initiated community-based system of

care for children and youth with special health care needs. This initiative complements the American Academy of Pediatrics belief that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent.

Five RMHSCs will be contracted as of July of 2005. Through linkages, the outcome is for the RMHSC to increase the number of children screened and identified with special health care needs in the region by coordinating family support services and respite care, educating health and social service providers on the resources available to families of CYSHCN, collaborating with community-based organizations, colleges and universities in the state, particularly those with training programs for students who want to provide services to CYSHCN; and promoting the development of respite care practicum programs that link students to families who need respite care services.

/2008/ The medical home program is transitioning from a center based approach to a community based approach./2008/

8. Reduce health disparities especially related to Access to care, Race/ethnicity, and Geographic location. (Specific issues: teen pregnancy, low birthweight, prenatal care, breastfeeding, and infant mortality)

Compared to national statistics, CT residents report good health status overall, however, large health disparities exist between the White population and that of the African American/Black and Hispanic populations within CT. This issue was identified in the last needs assessment conducted four years ago, and remains one that DPH needs to focus efforts. Specifically, lack of access to health care for low income and uninsured populations differs across these populations. Even women with health insurance lack access to mental health, oral health and specialty care services including follow-up procedures and testing due, in part, to high out-of-pocket expenses.

Lack of access to basic needs negatively impacts overall health status of target populations. There are documented delays in seeking care by hidden populations including undocumented, immigrants and refugees. In general, these populations are not seeking routine and preventive care due to both perceived and actual barriers, which contributes to poor health outcomes and a greater burden on the health care delivery system. Significant health disparities are documented with African American/Black and Hispanic populations experiencing dramatically poorer health status. While the overall percent of births to teens has dropped in the last decade, especially among African Americans/Blacks, there remain a greater percentage of pregnancies among these teens when compared to white teens.

While there was no specific SPM developed for this priority need, the goal to reduce health disparities has been incorporated explicitly in two of the SPMs, e.g. the reduction of intentional injuries and infants whose mother received prenatal care in the first trimester. All of CT's MCH programs collect standardized racial and ethnic information of populations they serve with the overarching goal to monitor whether or not these programs are meeting the needs of all sub-populations.

/2008/ The PHI Branch convened an internal Health Disparities workgroup./2008/

9. Collaborate with the other federal Region I states to develop indicators that measure the collective assets of their early childhood health systems, "specifically focusing on their collective assets regarding child care health consultants (CCHC)."

SPM to be determined. /2007/The language of this performance measure has been formalized by participating Region I states as "Percent of licensed child care centers serving children age birth to five who have on-site health consultation, as defined by the standards in Caring for Our Children: 'Center-based facilities that serve any child under 2 years of age shall be visited at least once a month by a health professional with general knowledge and skills in child health and safety. Center-based facilities that are not open 5 days a week or serve only children 2 years and

older shall be visited at least quarterly on a schedule that meets the needs of the composite group of children."//2007//

/2008/ This SPM was updated to reflect information that can be obtained from the database. Please refer to the SPMs section//2008//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	43	41	43	56	42
Denominator	43	41	43	56	42
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100

Notes - 2006

Source: CY2006 CTDPH Newborn Screening Program, Family Health Section

Notes - 2005

Source: CY2005 CDPH Newborn Screening program supplied the percentage of confirmed cases who also received appropriate followup. (For more info on CT's newborn screening procedures/data see also the detailed note with Form 6)

Notes - 2004

Source: CY2004 CDPH Newborn Screening program supplied the percentage of confirmed cases who also received appropriate followup. (For more info. on CT's newborn screening procedures/data see also the detailed note with Form 6.)

a. Last Year's Accomplishments

CT met this objective by assuring that 100% of infants screened as positive with condition(s) received follow-up to definitive diagnosis and clinical management. Of 42,180 infants born in CT in 2006, 99% received newborn screening (NBS) prior to discharge or within first week of life. All 2,630 suspect positive results were reported to Regional Treatment Centers and/or primary care physicians for further testing and follow-up. Of these, 60 were confirmed as disease cases and 894 Hemoglobin traits were identified.

Of 246 cases of unsatisfactory NBS specimens, all but 2 were resolved with receipt of a 2nd specimen. There were 4 CT State Waivers submitted to the lab for refusal of screening due to conflicts with religious tenets, and 2 of these infants were later screened by their primary care provider. The NBS staff followed up on 210 infants who received a transfusion. Those who were transfused prior to NBS blood test were tracked until specimen (Hemoglobinopathies and

Galactosemia) was collected 90 days after last transfusion.

NBS Program Laboratory and Tracking staff met monthly to address quality assurance, statistical reporting and emerging genetic issues. NBS staff met quarterly with the Genetics Advisory Committee to discuss and address current and emerging issues related to NBS, potential expansion, and proposed NBS legislative bills.

NBS staff provided education and TA to birthing facility health professionals, primary care providers, families, nurse midwives and general public. The Genetic NBS website was reviewed and updated to reflect changes in the screening panel, and current statistical information.

NBS staff served on regional workgroups including the New England Consortium of Metabolic Disorders, NERGG Board of Directors, New England Public Health Genetic Education Collaborative (funded by HRSA) which included families who have children identified with genetic/metabolic disorders, workgroups involved with transition (pediatric to adult), and the development of a regional NBS brochure (that was translated into 15 languages that was used as a regional model [8 posted on web-site--7 pending]).

Regional Treatment Center Genetic Specialists provided NBS educational programs through grand rounds conferences throughout CT, partnered with Hospital for Special Care SCD needs assessment to identify gaps in care, services and developed a statewide sickle cell plan to begin to address the provision of services for those with sickle cell disease or trait.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the quarterly Genetics Advisory Committee(GAC) meetings				X
2. Work with other groups to provide education on Genetics and NBS		X		
3. Screen all infants for selected metabolic or genetic disorders			X	
4. Refer newborns with abnormal screening results for appropriate services			X	
5. Update educational programs to reflect the expansion of the NBS testing panel				X
6. Participate in various State, Regional, and National conferences				X
7. Support families identified with genetic and metabolic disorders		X		
8.				
9.				
10.				

b. Current Activities

DPH ensures early identification of infants at increased risk for selected metabolic or genetic disorders. NBS Tracking staff will be relocating to the State Laboratory. Monitoring of legislative bill proposing universal screening for Cystic Fibrosis continues. With Genetics Advisory Committee specialists, DPH is revising birthing facility & primary care provider guidelines, protocols & resources to reflect expansion of NBS testing panel.

To enable prompt identification of disorders & referrals to treatment centers for confirmation testing, treatment, education, counseling & follow-up services, quality improvement reviews are ongoing. Activities include monthly meetings with lab staff to discuss program & QA issues

(unsatisfactory specimens, CT Waivers for objection to testing, transfusions & timely receipt of NBS specimens) & participation in the National Genetic NBS Genetic Resource Center to discuss the Program Evaluation and Assessment Scheme (PEAS), a NBS self-evaluation tool.

The NBS System of electronic reporting of demographic and lab testing information continues to be utilized by birthing facilities. Inclusion of a non-participating birthing facility and a midwife practice that performs ~250 births per year is underway.

The NBS program developed a free web-based training program for NBS treatment center specialists, healthcare providers & health professionals that offered CME and Nursing Contact Hours.

c. Plan for the Coming Year

CT will assure that infants are screened for genetic disorders, adding other selected metabolic or genetic disorders to the screening panel when appropriate. All newborns with abnormal screening results will continue to be referred to state Regional Treatment Centers for comprehensive testing, counseling, education, and treatment services so that medical treatment can be promptly initiated.

Quality improvement reviews will be conducted to assure that all newborns are screened in a timely and accurate manner to enable prompt identification of disorders and referrals to State designated Regional Treatment Centers for confirmation testing, treatment, education, counseling, and follow up services.

NBS staff will work collaboratively with the GAC, the specialty treatment centers, and others in the development and implementation of educational materials and programs. DPH will continue to enhance the website with additional information and explore other opportunities for web-based educational programs. NBS staff will continue to participate and collaborate on the implementation of the CT Genomic Action Plan.

If the legislative bill proposing the addition of Cystic Fibrosis to the NBS panel is passed, NBS staff will revise guidelines, protocols, brochures, and fact sheets to reflect the change.

CT will participate in the HRSA grant awarded to the New England Regional Genetics Group, Inc., (NERGG) New England Genetic NBS Collaborative Projects. CT DPH will continue to collaborate with the NERGG and will seek other funding opportunities to address the program's genetic, NBS and transition to adult care needs. Staff will also participate on the New England Consortium of Metabolic Disorders Group and various NE projects and programs.

Staff will participate on the various Sickle Cell infrastructure development meetings (Sickle Cell Stakeholder's group) and partner with community-based organizations in their current and new activities.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		59.8	59.8	59.8	59.8
Annual Indicator	59.8	59.8	59.8	59.8	59.8

Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	2008	2009	2010	2011
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8

Notes - 2006

The data reported in 2006 are from the most recent SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2004 for this performance measure. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments

CT successfully met this objective. According to data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted from October 2000 to April 2002, 59.8% of families of CSHCN in CT partner in decision-making and are satisfied with the services received, compared to 57.5% nationally.

The Regional Medical Home Support Centers (RMHSC) continued to fulfill their responsibilities related to the establishment and growth of family and professional partnerships. The RMHSC and the Regional Family Support Network (RFSN) worked together to expand the level of support, information, referral and networking available to families. The RFSN was available to assist families with questions, family-to-family support, and family empowerment. The RFSN was available to assist RMHSC with family-centered training and capacity building.

The RFSN held family forums covering respite, understanding the special education system, and assuring cultural diversity in system planning. RFSN members shared information learned at family forums with all members of RMHSCs and DPH staff at monthly RMHSC meetings. RFSN individuals have affiliations with other statewide organizations including the African Caribbean American Parents of Children with Disabilities, Family Support Network (affiliated with the legislated Family Support Council), and special education parent organizations.

Families were active members of the Family Support Council, CT Lifespan Respite Coalition and Family Voices. DPH compensated families to review CT's Title V Application and invited families to comment at the MCHBG public hearing.

The Medical Home Advisory Council, consisting of over 25 stakeholders including parents/caregivers of CYSHCN who are compensated for their time, was established to improve the system of care for CYSHCN needs by connecting them to a medical home. The Council hosted a planning retreat to set the direction for 2007-2009 by designing a strategic roadmap to develop an integrated, sustainable model for a statewide medical home system. Approximately 40 participants attended the event including parents/caregivers of CSHCN who were

compensated for their participation.

DPH participated in a collaborative, including family groups and providers, that received a grant award from the Centers for Medicare and Medicaid (CMS) for a Family-to-Family Health Information Network. The group hosted training to over 90 families and providers statewide that covered information about HUSKY and private insurance, Social Security, Title V and Medical Home.

DPH distributed the Get Creative About Respite manual and began editing a new organizer for families/caregivers of CYSHCN entitled Directions: Resources for Your Child's Care. The DPH Family Advocate was available to all MCH Programs within DPH, RMHSC, Medical Homes and Regional Family Support Network.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage families to participate in Family Forums, RMHSC meetings, Medical Home Advisory Council, Block Grant review, other councils (i.e. Family Support Council) and meetings as appropriate				X
2. Support families to participate through training and mentoring and compensate for time and knowledge				X
3. Provide trainings for families on statewide and local supports, link families to existing trainings and other resources				X
4. Have families provide training for all stakeholders and encourage sharing lessons learned				X
5. Assure families from diverse backgrounds are involved				X
6. Distribute family surveys		X		
7. Establishment and growth of family/professional partnership				X
8. Provide families with tools such as "Get Creative About Respite" & "Directions"		X		
9.				
10.				

b. Current Activities

The RMHSC & Regional Family Support Network help expand the level of resources available to families. RFSN hosts family forums to share resources & provide solutions for needed services and supports.

RFPs exist to transition care coordination & services for CYSHCN from the RMHSC towards community-based medical homes. Anticipated implementation is July 1, 2007. Contractors will provide services in management of extended services & respite funds, care coordination, education & family support.

Families participate & are compensated for their work on the legislated Family Support Council, CT Lifespan Respite Coalition, Family Voices, Medical Home Advisory Council & review of CT's MCH Block Grant. A family member from the Council was awarded a family scholarship to AMCHP's National Convention in Washington D.C.

DPH continues to participate as a partner in the management team overseeing the Family-to-Family Health Information Network. RMHSCs proactively provide information & resources to Medical Home practices. The Network assists families in negotiating the complex system of health services and health care access, including funding and reimbursement.

DPH continues to enhance the statewide respite system available through RMHSCs. DPH distributes the Get Creative About Respite & Directions: Resources for Your Child's Care manuals through community activities & electronically through DPH website.

The DPH Family Advocate is available to all MCH programs within DPH & their partners.

c. Plan for the Coming Year

The DPH will support and enhance the family-centered Medical Home concept in CT through a contractor who will provide statewide outreach and culturally competent education to pediatric primary care providers and families on the concept of medical home for CYSHCN, and link these children to medical homes and family support services.

Family support services will include providing assistance and culturally appropriate education to families of CYSHCN that will enable families to acquire skills necessary to access needed medical and related support services. Families will learn to link to needed supports and become empowered, competent supporters for their children.

The contractor (CHDI) will work with pediatric primary care settings to survey for knowledge regarding the concept of medical home and/or assistance with establishing or linking with medical homes for the targeted population and conduct culturally appropriate training for families and providers.

Families will continue to be active members of the Medical Home Advisory Council, the legislated Family Support Council, CT Lifespan Respite Coalition and Family Voices.

DPH will promote the partnering of families in decision making for CSHCN. These activities will include but not be limited to: compensation for families to review CT's Title V Maternal and Child Health Block Grant (MCHBG) application, invitation for families to comment at the MCHBG public hearings or focus groups, distribution of the Get Creative About Respite and Directions: Resources for Your Child's Care manuals, provision and support of an Access database to manage and report information on CYSHCN, and partnership in the Family-to-Family (F2F) Health Information Network management team.

The DPH Family Advocate will remain available to all MCH Programs within DPH, Medical Homes, and the Regional Family Support Network.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		56.9	56.9	56.9	56.9
Annual Indicator	56.9	56.9	56.9	56.9	56.9
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2007	2008	2009	2010	2011
Annual Performance Objective	56.9	56.9	56.9	56.9	56.9

Notes - 2006

The data reported in 2006 are from the most recent SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2005

The data reported in 2005 from the SLAITS Survey have pre-populated the data from 2004 for this performance measure.

Notes - 2004

The data reported in 2002 from the SLAITS Survey have pre-populated the data for 2004 for this performance measure.

a. Last Year's Accomplishments

CT successfully met this objective. According to data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted from October 2000 to April 2002, 56.9% of families of CSHCN ages 0 to 18 received coordinated, ongoing and comprehensive care in a medical home, compared to 52.6% nationally. DPH continued to implement the five new Regional Medical Home Support Centers (RMHSCs) to enable Children and Youth with Special Health Care Needs (CYSHCN) to receive coordinated, ongoing, comprehensive care in their local communities. The goals of this community-based system of care are to: 1) reach more CYSHCN and their families and assist them with coordination of the multiple systems of care they need to access; 2) provide training and support to pediatric primary care providers (PCPs) to improve quality of care by addressing family needs that will optimize the health of CYSHCN; 3) assist pediatric PCPs with care coordination for CYSHCN who have high severity needs; 4) assist with coordination between pediatric PCPs and specialists; and 5) promote the establishment of "medical homes" with pediatric PCPs that care for CYSHCN.

DPH assisted the RMHSCs with developing a medical home provider network by: 1) training medical home staff on use of the CSHCN Screener and Complexity Index tools; and 2) facilitating practice improvement changes.

DPH worked with the RMHSCs and medical homes to facilitate family-professional partnerships by selecting and engaging parent partners to connect families with support services, access respite funds, and to strengthen the respite planning process.

DPH disseminated the Medical Home Academy (MHA) curriculum to pediatric health care providers and families through its website. The MHA presented the practical and effective practice improvement methodology needed to enhance coordinated, ongoing, comprehensive care for CYSHCN and their families. For more information, see website: <http://www.dph.state.ct.us>.

The Medical Home Advisory Council (MHAC), consisting of over 25 stakeholders, was established to improve the system of care for children and youth with special health care needs by connecting them to a medical home that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. The Council hosted a planning retreat to set the direction for 2007-2009 by designing a strategic roadmap to develop an integrated, sustainable model for a statewide medical home system.

DPH staff participated on the MHAC subcommittee on reimbursement for care coordination to identify reimbursement strategies to support medical homes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement, monitor and evaluate Regional Medical HomeSupport Centers (RMHSCs)				X
2. Assist RMHSCs with developing a medical home provider network				X
3. Work with RMHSCs and medical homes to facilitate family-professional partnerships				X
4. Disseminate Medical Home Academy curriculum				X
5. Participate on Medical Home Advisory Council				X
6. Provide families with tools such as "Get Creative AboutRespite" and "Directions"		X		
7.				
8.				
9.				
10.				

b. Current Activities

DPH provides assistance to the RMHSCs with developing a medical home provider network through outreach materials for presentations and works with the RMHSCs and medical homes to facilitate family-professional partnerships by engaging parent partners to connect families with support services and share information about statewide and community supports through forums as well as electronically through a list serve.

RFPs were issued to transition care coordination and services for CYSHCN from the Regional Medical Home Support Centers towards more community based, culturally competent Medical Home concept in accordance with recent trends and direction from the MHAC. Anticipated implementation of the new model of services is July 1, 2007. Contractors will provide services in the following categories: management of extended services and respite funds; care coordination; and provider/family education and family support. An MOA is in place with The Children's Trust Fund to support transitioning from the RMHSC model towards the medical home model.

The Medical Home Advisory Council (MHAC) continues to implement their long-term comprehensive plan to improve the community-based system of care for CYSHCN.

DPH, in consultation with the Medicaid managed care organizations administering HUSKY A Plans in Connecticut, is taking the first steps in establishing a medical home pilot program to enhance health outcomes for children, including children with special health care needs.

c. Plan for the Coming Year

DPH provides assistance to the RMHSCs with developing a medical home provider network through outreach materials for presentations and works with the RMHSCs and medical homes to facilitate family-professional partnerships by engaging parent partners to connect families with support services and share information about statewide and community supports through forums as well as electronically through a list serve.

RFPs were issued to transition care coordination and services for CYSHCN from the Regional Medical Home Support Centers towards more community based, culturally competent Medical Home concept in accordance with recent trends and direction from the MHAC. Anticipated implementation of the new model of services is July 1, 2007. Contractors will provide services in

the following categories: management of extended services and respite funds; care coordination; and provider/family education and family support. An MOA is in place with The Children's Trust Fund to support transitioning from the RMHSC model towards the medical home model.

The Medical Home Advisory Council (MHAC) continues to implement their long-term comprehensive plan to improve the community-based system of care for CYSHCN.

DPH, in consultation with the Medicaid managed care organizations administering HUSKY A Plans in Connecticut, is taking the first steps in establishing a medical home pilot program to enhance health outcomes for children, including children with special health care needs.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		61.3	61.3	61.3	61.3
Annual Indicator	61.3	61.3	61.3	61.3	61.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	2008	2009	2010	2011
Annual Performance Objective	61.3	61.3	61.3	61.3	61.3

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2005

The data reported in 2005 from the national SLAITS survey have pre-populated the data from 2004 for this performance measure.

Notes - 2004

The data reported in 2002 from the national SLAITS Survey have pre-populated the data for 2004 for this performance measure.

a. Last Year's Accomplishments

CT successfully met this objective. Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October 2000 and April 2002 indicated that in CT, 61.3% of the families of children with special health care needs (CSHCN) have adequate private and/or public insurance to pay for the services/equipment they need.

The CT Regional Medical Home Support Center (RMHSC) System of Care for CYSHCN was designed to increase the number of CYSHCN that receive family-centered, coordinated care through community-based health care systems using Title V funds; and improve availability of programmatic and health care service data on CYSHCN from which to evaluate the system and

develop quality improvement programs.

RMHSC Care Coordinators identified alternate sources of payment for services for families and provided coordination of services. Of the 2,354 CYSHCN served by the RMHSC 2,073 had adequate insurance coverage (88.1%).

The increased number of CYSHCN identified by the RMHSCs increased the number of CYSHCN requesting extended service funds (ESF). A number of families whose insurance companies were not based in Connecticut reported those companies were not required to adhere to Connecticut Insurance Laws and families were often denied benefits without legal recourse.

DPH collaborated with United Way of Connecticut 2-1-1 Infoline/Child Development Infoline (CDI) to identify resources for CYSHCN and their families/caregivers. This included linking eligible families with HUSKY to obtain medically necessary services in accordance with EPSDT requirements.

The Medical Home Advisory Council (MHAC) hosted a planning retreat in September 2006 to set the direction for 2007-2009. This retreat resulted in the design of a strategic roadmap for an integrated, sustainable model for a statewide medical home system with core components of quality improvement, family-provider partnerships and care coordination.

DPH collaborated with family groups and providers who received a grant award from the Centers for Medicare and Medicaid (CMS) for a Family-to-Family Health Information Network. The Network, made up of parents and caregivers of children and youth with special health care needs, assists families in negotiating the complex system of health services and health care access, including funding and reimbursement. The RMHSCs worked with the Family-to-Family Health Information Network to provide information and resources to fifty Medical Home practices per year. The group hosted training that covered information about Husky Health Insurance, private insurance, Social Security, Title V, and Medical Home.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess family's insurance status		X		
2. Provide education on benefits/services provided by insurance/other programs				X
3. RMHSC and Medical Homes identify CYSHCN and provide care coordination including access to private/public insurance		X		
4. Coordinate with HUSKY Infoline		X		
5. Work with Medicaid Managed Care Council and DSS to ensure CYSHCN population is identified, provided all needed services, and providers are reimbursed for identification and care coordination services				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Connecticut System of Care for CYSHCN entitled "Regional Medical Home Support Center (RMHSC) System of Care for Children and Youth with Special Health Care Needs," is being transitioned from a center model to a more community-based model and is recruiting primary care

practices (medical homes) to identify children with special health care needs (CSHCN) utilizing the FACCT CSHCN Screener(c) to identify the complexity involved in supporting CSHCN. Care coordinators at the RMHSCs/medical homes support coordination of services for children/youth/families referred by PCPs.

The RMHSC provide care coordination services, including benefits coordination, for families of CYSHCN to assist in accessing public/private source(s) to pay for services needed.

RFPs have been issued to transition care coordination and services for CYSHCN from the RMHSCs towards more community based, culturally competent Medical Homes in accordance with recent trends and direction from the MHAC. Anticipated implementation of the new model of services is 7/1/07. Contractors will provide services in the following categories: management of extended services and respite funds; care coordination; and provider/family education and family support. An MOA is in place with The Children's Trust Fund to support transitioning from the RMHSC model towards the medical home model. A "kickoff" meeting for new contractors was held to orient providers on collaborations and expectations for the new service system.

c. Plan for the Coming Year

The DPH will support the family-centered medical home concept in Connecticut by the selection of a contractor (CHDI) to provide statewide outreach and culturally competent education to pediatric primary care providers and families on the concept of medical home for children and youth with special health care needs. Additionally these children will be linked to medical homes, when available, and family support services.

Family support services will include providing assistance and culturally appropriate education to families of CYSHCN that will enable families to acquire the skills necessary to access needed medical and related support services. Families will learn to link to needed supports which, in turn, will help to empower them to become competent supporters for their children.

CHDI will work with pediatric primary care settings to survey for knowledge regarding the concept of medical home and/or assistance with establishing or linking with medical homes for the targeted population and conduct culturally appropriate training for families and providers.

The contractors for care coordination services will enhance the statewide implementation of the system to serve families of CYSHCN with comprehensive, accessible, coordinated care including access to adequate public and or private insurance to pay for services families need.

DPH staff will represent the Department at the Connecticut Medicaid Managed Care and Developmental Disabilities Councils.

DPH, in consultation with Medicaid managed care organizations administering HUSKY A Plans will continue a medical home pilot program to enhance health outcomes for children, including children with special health care needs. One year from inception of the project, the DPH Commissioner will report specific improved health outcomes and cost efficiencies achieved to the General Assembly.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		76.8	76.8	76.8	76.8
Annual Indicator	76.8	76.8	76.8	76.8	76.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	2008	2009	2010	2011
Annual Performance Objective	76.8	76.8	76.8	76.8	76.8

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2005

The data reported in 2005 from the national SLAITS Survey have pre-populated the data from 2004 for this performance measure.

Notes - 2004

The data reported in 2002 from the national SLAITS Survey have pre-populated the data for 2004 for this performance measure.

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October 200 and April 2002 indicated that in CT, 76.8% (95% CI: 71.2, 82.4) of families of CSHCN ages 0 to 18 reported community-based systems are organized so families can use them easily. This percentage is no different from the national estimate of 74.3% (95% CI: 72.9, 75.7).

The Connecticut Title V System of Care for CYSHCN completed the transition to regional centers during this year. The new system is entitled "Regional Medical Home Support Center System of Care for Children and Youth with Special Health Care Needs" (RMHSC). RMHSCs are expected to enable Children and Youth with Special Health Care Needs (CYSHCN) to receive coordinated, ongoing, comprehensive care in their local communities. The goals of this community-based system of care: 1) reach more CYSHCN and their families and assist them with coordination of the multiple systems of care they need to access; 2) provide training and support to pediatric primary care providers (PCPs) to improve quality of care by addressing family needs that will optimize the health of CYSHCN; 3) assist pediatric PCPs with care coordination for CYSHCN who have high severity needs; 4) assist with coordination between pediatric PCPs and specialists; and 5) promote the establishment of "medical homes" with pediatric PCPs that care for CYSHCN.

DPH collaborated with United Way of CT 2-1-1/Child Development Infoline (CDI) to implement a referral and coordination of services system to assess and refer CYSHCN and their families to the RMHSCs. Monthly teleconferences were held to review complex cases receiving care and to share resources.

The Medical Home Advisory Council (MHAC) formed by DPH, includes representatives from families/caregivers of CYSHCN, the RMHSCs, service providers, and public and private agencies. The MHAC provides DPH with guidance and advice on its efforts to improve the community-based system of care for CYSHCN by ensuring their connection to a medical home

that is accessible, compassionate, comprehensive, continuous, coordinated, culturally effective and family-centered.

The Medical Home Advisory Council (MHAC) hosted a planning retreat in September 2006 to set the direction for 2007-2009. This retreat determined the core components of the model system will be quality improvement, family-provider partnerships, and care coordination and community partnerships.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement, monitor and evaluate Regional Medical Home Support Centers				X
2. Implement, monitor and evaluate referral and coordination of services system with United Way of Connecticut 2-1-1 Infoline/Child Development Infoline				X
3. Implement recommendations from Medical Home Advisory Council strategic planning process				X
4. Enhance public/private partnerships with agencies and organizations serving CYSHCN and their families				X
5. Develop and release requests for proposals to expand the medical home concept throughout Connecticut				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Connecticut System of Care for CYSHCN entitled "Regional Medical Home Support Center (RMHSC) System of Care for Children and Youth with Special Health Care Needs," is being transitioned from a center model to a more community-based model and is recruiting PCPs (medical homes) to identify children with special health care needs (CSHCN) utilizing the FACCT CSHCN Screener(c) to identify the complexity involved in supporting CSHCN. Care coordinators at the RMHSCs/medical homes support coordination of services for children/youth/families referred by primary care providers.

The RMHSC provide care coordination services, including benefits coordination, for families of CYSHCN to assist in accessing public/private source(s) to pay for services needed.

RFPs were issued to transition care coordination and services for CYSHCN from the RMHSCs towards more community based, culturally competent Medical Homes in accordance with recent trends and direction from the MHAC. Anticipated implementation of the new model of services is 7/1/07. Contractors will provide services in the following categories: management of extended services and respite funds; care coordination; and provider/family education and family support. A memorandum of agreement is in place with The CTF to support transitioning from the RMHSC model towards the medical home model. A "kickoff" meeting for new contractors was held to orient providers on collaborations and expectations for the new service system.

c. Plan for the Coming Year

The Department will advance the family-centered medical home concept in Connecticut. A contractor has been selected to provide statewide outreach and culturally effective education to pediatric primary care providers and families on the concept of medical home for children and youth with special health care needs.

Family support services will include providing assistance and culturally effective education to families of CYSHCN. This will enable families to acquire the skills necessary to access needed medical and related support services. It will also promote learning how to link to needed supports. This will, in turn, help empower families to become competent supporters for their children.

DPH will monitor and evaluate the new community-based system of care to enable Children and Youth with Special Health Care Needs (CYSHCN) to receive coordinated, ongoing, comprehensive care in their local communities.

DPH will collaborate with United Way of CT 2-1-1/Child Development Infoline (CDI) to implement a referral and coordination of services system to assess and refer CYSHCN and their families to the new system. This will involve CDI steering committee meetings and monthly conference calls to discuss care coordination challenges and resolutions..

DPH will maintain public/private partnerships with other organizations that serve CYSHCN and their families. The Medical Home Advisory Council will implement and evaluate the long-term comprehensive plan to improve the community-based system of care for CYSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		5.8	5.8	5.8	5.8
Annual Indicator	5.8	5.8	5.8	5.8	5.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2007	2008	2009	2010	2011
Annual Performance Objective	5.8	5.8	5.8	5.8	5.8

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2005

The data reported in 2005 from the national SLAITS Survey have pre-populated the data from 2004 for this performance measure.

Notes - 2004

The data reported in 2002 from the national SLAITS Survey have pre-populated the data for 2004 for this performance measure.

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October, 2000 and April, 2002 indicated that in CT, 3.5 % (+/- 2.8%) of CYSHCN received the services necessary to make transitions to adult life. This percentage was lower than the national estimate of 5.8 % (95% CI 4.6, 7.0), but the number of families in CT who responded positively to this question was (n=6), and the percentages were not statistically different.

As of July 1, 2005, DPH transitioned from two to five regional centers serving CYSHCN. The Regional Medical Home Support Centers (RMHSC) enrolled primary care practices to screen CYSHCN and identify the level of complexity/intensity involved in supporting them in the practice. Care coordinators of the RMHSC supported the need for coordination of services for those children/youth/families, when the primary care provider refers the family. When the family self-refers, the RMHSC staff collaborated with their primary care provider.

DPH promoted transition for youth with special health care needs (YSHCN) to all aspects of adult life by optimizing the resources of interagency community teams. DPH contracted with the University of Connecticut A. J. Papanikou Center for Developmental Disabilities to improve interagency care/service coordination for CYSHCN. This involved meetings with managers of key state agencies to identify existing service delivery mandates for state agencies to provide care coordination. A statement of common elements of care coordination across agencies was developed.

A decision was made to focus the efforts of the follow-up regional interagency meetings on care coordination issues specific to the transition of YSHCN to all aspects of adult life. Each RMHSC identified YSHCN ages sixteen and older who need assistance with transition planning. Technical support was provided to each RMHSC to develop regional inter-agency care coordination councils. The initial meetings of these regional councils focused on provision of service coordination for an identified YSHCN and their family who needed in-depth planning across agencies. The response to these YSHCN transition planning meetings was highly favorable.

Each RMHSC identified YSHCN ages sixteen and older who need assistance with transition planning. Technical support was provided to each RMHSC to develop regional inter-agency care coordination councils. The initial meetings of these regional councils focused on provision of service coordination for an identified YSHCN and their family who needed planning across agencies.

The Connecticut Medical Home Initiatives for CYSHCN training module entitled "Medical Home and Transition: Growing Up on and Moving On" was made available in distance learning formats for individual or group education.

DPH received technical assistance funds from HRSA to contract a consultant to assist in the development of a comprehensive statewide Sickle Cell Disease plan. The comprehensive plan will be used to leverage funding to provide quality healthcare services for young adults and adults to access transitional services for adults with sickle cell disease. The plan also identifies the infrastructure needs and the cost analysis of the lack of these services in CT.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify youth with special health care needs			X	
2. Identify and strengthen relationships with schools, community-				X

based organizations and State Agencies				
3. Provide children and families individualized transition packets		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RMHSCs identify YSHCN 14 years and older in their databases who should have an interagency care plan. RMHSC expanded beyond the original group of YSHCN 16 years and older to develop transition plans for all YSHCN by age 14.

The facilitation of the transition process for YSHCN has included the identification and education of pediatric/adolescent/family practice primary care providers (PCP) who are interested in practicing successful YSHCN health care transition. Providers are offered the Connecticut Medical Home Initiatives for CYSHCN training module entitled "Medical Home and Transitions: Growing Up and Moving On" presented by Dr. Karen Rubin.

Connecticut is establishing relationships with national groups such as Healthy and Ready to Work (HRTW) to further enhance their infrastructure building to achieve successful transition to all aspects of adult life for YSHCN.

RMHSC and DPH are partnering with state agencies to distribute transition resources to YSHCN and their families/caregivers as well as service providers. Examples of these resources include: (1) BUILDING A BRIDGE From School To Adult Life For Young Adults With Disabilities In Connecticut an, (2) Transition Planning for Adolescents with Special Health Care Needs,

The Statewide Sickle Cell plan is currently being implemented through the Hospital of Special Care who is taking the lead on building the SCD infrastructure, prioritizing the recommendations and implementing activities as identified.

c. Plan for the Coming Year

DPH will enhance the Medical Home concept working with CHDI to provide statewide outreach and culturally competent education to pediatric primary care providers and families on the concept of medical home for CYSHCN and link these children to medical homes and family support services, including assistance and culturally appropriate education to families of CYSHCN to empower families to become competent supporters for their children.

Contractors will expand upon DPH efforts to strengthen Interagency Care Coordination Collaboration for Youth with Special Health Care Needs (YSHCN) in Transition. YSHCN 14 years and older will be identified and assisted with developing an interagency transition plan.

Contractors will continue DPH efforts to expand the identification and education of pediatric/adolescent/family practice primary care providers interested in practicing successful YSHCN health care transition. Providers will be encouraged to become medical homes and to use the CYSHCN training module, "Medical Home and Transitions: Growing Up and Moving On" presented by Dr. Karen Rubin, available in distance learning formats including the DPH website.

CT will expand inclusion of youth and family partners in the system process of transition to a meaningful and productive adult life. DPH and its contractors will expand identification of youth

and family advocacy groups to collaborate in this work, including: achieving the six YSCN Performance Measures; membership on the MHAC; advisement on initiating a quality assurance process to identify YSHCN who receive desired services and supports by age 21; and YSHCN transition resources.

CT will expand relationships with local, regional and national groups such as Healthy and Ready to Work to further enhance their infrastructure building to achieve successful transition to all aspects of adult life for YSHCN.

DPH recognizes the need to promote the successful transition of YSHCN and will research additional resources to support the process to promote the successful transition of YSHCN.

The Statewide Sickle Cell plan will be used to implement a variety of activities: The plan will be disseminated to additional key stakeholders and placed on the DPH website. The SCD Stakeholder group has developed an Education Committee to develop a media campaign on SCD. The campaign will consist of public health service announcements, brochures, kiosks, and displays to provide education and awareness information to families, patients, providers, and the general public.

As part of the activities of the Infoline MCH Advisory Committee, DPH is working with United Way of CT to convene a December meeting on transition for the MCH population. It is anticipated that Patti Hackett and Dr. Patience White will be the guest speakers. A forum for providers will be planned for the morning, and one in the evening for parents.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	90	82	91.4	92.8	88.2
Annual Indicator	78.0	91.1	92.4	87.8	86.1
Numerator	67372	78103	79216	74327	
Denominator	86374	85734	85732	84655	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	88.6	89	89.4	89.8	89.8

Notes - 2006

Source: NIS 2005, Centers for Disease Control
(www.cdc.gov/nip/coverage/NIS/05/tab03_antigen_states)

Note: This sample value has a confidence interval of plus or minus 5.4 which would include our targetted objective of 88.2.

Notes - 2005

Source: See website: www.cdc.gov/nip/coverage/nis/04/tab02antigen_state
 CDC NIS data Q12004-Q42004 survey for 4: 3: 1: 3: 3:.. CT ranks among the top 3 states for immunization success rate. Denominator represents CY2001-2002 resident births. The numerator is not an actual #, but a synthetic estimate based on the percentage derived from the National Immunization Survey Sampling data of children with DOB 2/01-5/03.

Notes - 2004

Source: Centers for Disease Control N.I.S. data Q32003-Q22004 survey for 4: 3: 1: 3: 3:.. CT ranks #1 among states for immunization success rate. Denominator represents CY 2001-2002 resident births. The numerator is not an actual #, but a synthetic estimate based on the percentage derived from the National Immunization Survey Sampling data of children with DOB 8/00-11/02.)

a. Last Year's Accomplishments

According to the Centers for Disease Control National Immunization Survey for 2005, 81.5% (+/- 6.1%) of children age 19-35 months have completed immunizations in Connecticut (http://www.cdc.gov/nip/coverage/nis/05/tab02_antigen_state.xls). The percentage reported is based on a telephone survey of reported vaccinations on records for the 6 reportable vaccines. Based on the current NIS data, Connecticut's immunization rate was ranked eighth among the states and well above the 76.1% national average. Connecticut has been among the top ten states for childhood immunization coverage levels for the past ten years. Connecticut's projected immunization rate for this year was 88.2. The most recent percentage reported by the NIS (2004 data) was 81.5% with a confidence interval of +6.1%. This confidence interval is not statistically different from the state projected percentage. Therefore, CT has met its projected goal.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor infants and children for compliance with immunization schedules	X			
2. Outreach and identify infants and children for up-to-date immunizations		X		
3. Provide support, information and linkage to necessary services		X		
4. Procure and provide publicly purchased vaccines		X		
5. Provide funding and technical support to health care providers to improve childhood immunization levels				X
6. Provide WIC check box to identify up to date immunization status			X	
7.				
8.				
9.				
10.				

b. Current Activities

RFTS, Comadrona, Healthy Start and HCWC provide case management services to pregnant women and their children, monitor, encourage and educate parents regarding the importance of keeping well child care visits. The CYSHCN program assesses children for required immunizations and refers them to appropriate resources. Care coordination is used to support families in accessing services.

The WIC Program continues to encourage parents and caregivers to obtain well childcare and

refers participants to eligible programs. The CT WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The Immunization Program continues to provide funding to support the Connecticut Immunization Registry and Tracking system (CIRTS) and provides funding to 16 contractors to conduct immunization activities, procure and distribute publicly funded childhood vaccines. Contractor activities consist of: performing clinic immunization assessments to monitor immunization coverage rates for preschool children; coordinating and providing outreach and referrals for children identified by CIRTS who are behind in their immunizations; conducting immunization education campaigns that are culturally appropriate for pregnant women, new parents, and new immigrants; and provide training and support to medical providers who utilize the CIRTS.

c. Plan for the Coming Year

The Title V funded and non-funded programs, including CYSHCN, WIC, CHCs, and those that provide case management services to pregnant women, will continue their efforts described in the Current Activities Section. Provision of immunizations as part of well childcare is a recognized important component of protecting public health.

The immunization program will 1) continue to assess and monitor immunization rates including HEDIS (Health plan Employer Data and Information Set) immunization rates for children enrolled Medicaid Managed Care; 2) continue efforts to develop and deploy a web-based registry application in 2007; 3) convene local advisory/planning groups in all 16 Immunization Action Plan funded sites to improve immunization services for children in high risk areas; and 4) partner with community organizations, coalitions, businesses and public and private professional and civic organizations to promote childhood immunizations and vaccine safety.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	16.1	14	14	12.9	12.8
Annual Indicator	14.0	12.9	12.8	12.3	
Numerator	982	906	917	909	
Denominator	69947	69976	71623	74155	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2007	2008	2009	2010	2011
Annual Performance Objective	12.3	12.2	12.2	12.1	12.1

Notes - 2006

We do not anticipate having final 2005 and provisional 2006 data until a year from now i.e. 2008. The 2006 annual objective field is "locked in" from last year and will not allow us to change the

objective to reflect our most recent experience. If we were able to change this field we would have modified the objective for 2006 to read 12.3 NOT 12.8 which would be a goal in the OPPOSITE direction to an improved experience.

Notes - 2005

Source: CY2005 provisional data, CDPH, Vital Statistics

We do not anticipate having final 2005 and provisional 2006 data until a year from now. The 2006 annual objective field is "locked in" from last year and will not allow us to change the objective to reflect our most recent experience. If we were able to change this field we would have modified the objective for 2006 to read 12.3 NOT 12.8 which would be a goal in the OPPOSITE direction to an improved experience.

Notes - 2004

CY2004 Provisional CT DPH Vital Statistics.

We do not anticipate having final 2004 and provisional 2005 data until a year from now. The 2005 annual objective field is "locked in" from last year and will not allow us to change the objective to reflect our most recent experience. If we were able to change this field we would have modified the objective for 2005 to read 12.8 NOT 12.9 which would be a goal in the OPPOSITE direction to an improved experience.

a. Last Year's Accomplishments

CT has successfully reached the goal for the reporting year 2005, achieving a teen birthrate of 12.3 per 1,000 live births (projected goal: 12.3 per 1,000 live births). There were 909 births among the estimated 74,155 females aged 15-17 years for a birth rate of 12.3 per 1,000 live births.

The Abstinence Education Program targeted youth ages 10 and 11 years. This program included health education, peer counseling, adult mentoring, after-school supervision and parent/guardian participation whenever possible. An evaluation of program outcomes is being conducted by the University of CT.

The Adolescent Health Strategic Plan has identified as a goal that adolescents adopt behaviors that support healthy sexuality. An Implementation Group, consisting of key stakeholders and subject matter experts, was convened to develop specific objectives to reach this goal. The Perinatal Health Advisory Committee was reconvened and the committee is comprised of members from other State Agencies and associations as well as community-based providers.

The state Adolescent Health Coordinator is taking the lead on enhancing inter and intra-agency collaborative relationships in order to put forth a comprehensive statewide approach to teen pregnancy prevention. The Coordinator worked with John Snow, Inc. (JSI) to convene a workshop for Title V contractors as well as other key partners in teen pregnancy prevention efforts. Information was provided on the development, implementation, and evaluation of science-based teen pregnancy prevention programs. Resources for information and technical assistance on science-based approaches were distributed at the workshop. There were 96 participants who represented a wide range of organizations (i.e., local health departments, schools, insurance companies, college health staff, state agencies, community-based youth serving programs, etc.). To promote collaboration among this diverse partnership, networking opportunities were built into the day and a participant list was provided.

Three SBHC staff received scholarships to attend a workshop sponsored by the Massachusetts Alliance on Teen Pregnancy prevention. A scholarship is planned in May for a SBHC APRN to attend Harvard School of Medicine's "Postgraduate Course in Adolescent Medicine." The conference provides information that will enhance the practitioner's ability to provide office-based prevention services and counseling to adolescents. DPH convened a panel of key stakeholders (DPH staff, president of the Parent Teacher Association, Family Planning, SBHC coordinator, and representatives from two CBOs serving teens) to attend a two-day roundtable, "Engaging

Parents" that was sponsored by the National Campaign to Prevent Teen Pregnancy. The DPH Teen Pregnancy Prevention Workgroup continued to meet.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide risk assessments and referrals for reproductive health services			X	
2. Implement teen pregnancy prevention programs		X		
3. Collaborate with traditional and non traditional teen pregnancy prevention partners				X
4. Develop curriculum for addressing adolescent paternity for at-risk youth				X
5. Convene the interagency adolescent workgroup				X
6. Provide education opportunities to key stakeholders on best practices in teen pregnancy prevention and youth development				X
7. Establish an "Implementation Team" to address reproductive health and sexuality strategic issues identified as a priority in the State Adolescent Health Plan (activities will promote teen pregnancy, STD, and HIV prevention)				X
8.				
9.				
10.				

b. Current Activities

Best practices in teen pregnancy prevention workshop in collaboration with John Snow Institute (JSI) was held with approximately 75 participants who received information on choosing, implementing and evaluating science based programs. The workshops for school health practitioners and educators are in the planning stages and will be presented in the fall.

An interagency (SDE, DSS, DPH) and key stakeholder implementation team will be convening this summer to address reproductive health and sexuality strategic issues identified as a priority in the State adolescent health plan.

DPH is working with the SDE on efforts to promote the Coordinated School Health Model to school systems to assist in getting adolescents to adopt lifelong health promoting behaviors. The adolescent health coordinator continues to serve on a number of committees and task forces with the SDE. These include SDE Advisory Committee (Reproductive Health Guidelines), The HIV/STD Coordinated Health Education CADRE of Trainers, and the National Stakeholders Group.

In 2004 there were 856 documented births to fathers aged 19 or less; slightly higher than the 844 recorded in 2003. The FHS is collaborating with the DSS, DCF, Yale Consultation Center, CTF, The Community Action Agency of New Haven and the New Haven Family Alliance on Adolescent Paternity. One of the major goals of the collaborative is to develop a framework and activities to prevent adolescent male paternity by increasing their family planning skills.

c. Plan for the Coming Year

The Adolescent Health Strategic Plan and the Perinatal Health Strategic Plan continue to provide the blueprint for directing the Department's teen pregnancy prevention efforts. At least one recommendation from the AHSP and PHSP will be implemented next year.

DPH will partner with non-traditional partners including juvenile justice and foster youth programs, athletic associations, parent organizations, and other youth-serving civic associations and provide educational opportunities on evidence-based, culturally appropriate approaches to sexuality education and the curriculums that have been developed.

Staff will work with state partners to support parents/guardians in efforts in talking to adolescents about sexuality, by providing culturally appropriate information and materials, and supporting improved outreach efforts from schools, community organizations and peer educators. The Family Advocate will be utilized to assist in this effort.

It is anticipated that a new program that addresses pregnancy prevention will be implemented as of January 2008. This will be an RFP of the current Right from the Start and Comadrona programs and will focus on prevention of secondary pregnancies.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	30	26	30	30	30
Annual Indicator	26.0	26.0	26.0	26.0	11.4
Numerator	357	357	357	357	2984
Denominator	1374	1374	1374	1374	26171
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	12	13	14	15	16

Notes - 2006

Source: CT Voices for Children SFY06, HUSKY A population. Projections were made based on this data even though this data may not be representative of the population as a whole. Data from the state survey conducted this year should be available for next year's report.

Notes - 2005

Data for this measure requires a state survey of third grade children. CT has no new statewide data since the last such survey was funded SFY2000. There was a private regional survey conducted in NW CT this past year (2005) including 8 of our 169 towns. Data showed 47.5% of 3rd graders had received dental sealants. It should be noted that these towns were: a) more affluent than the rest of the state with a Per Capita Income (PCI) of \$36,370 vs. \$28,766 for the state, and b) less diverse with only 3.4% non-white vs. 18.4% for CT as a whole.

Notes - 2004

Data for this measure requires a state survey of third grade children. CT has no new data since the last such survey was funded SFY2000.

a. Last Year's Accomplishments

The Office of Oral Public Health collaborated with community-based stakeholders, the CT Coalition for Oral Health Planning (CCOHP), to draft a statewide Oral Health Improvement Plan. Goals and objectives for plan were presented to the public in a series of eight focus groups throughout the state. Additional presentations were made to the State Dental Association, Association of Pediatric Dentists, University of Connecticut School of Dental Medicine and state legislature. Based on comments from these groups, the plan was revised

The Governor's budget proposal to expand Medicaid coverage for dental sealants and implement the Access to Baby Care Program was approved by the legislature. This is a best practice oral health program that involves physicians in the early identification of oral disease and prevention. Funding was allocated to the CT Dept. of Social Services (DSS) for implementation. The Office has offered to collaborate with DSS to assist in implementation.

The second volume of the oral health newsletter, Oral Health Matters, featured the Hartford Public School System's sealant program. Titled "KidSeal Spectacular", article outlined logistical and programmatic lessons learned in the first year of the program.

In 2004, the BRFSS surveyed adults 18 years of age and older regarding sealant placement on children in the household. Approximately 54 percent of the households with children between the ages of 6 and 15 were reported to have children with dental sealants. That percentage was higher for households where the respondent was white, had higher incomes, had more education or if the respondent had health care coverage. Whites report 60 percent of children in the household with sealants versus Blacks with 40%. Hispanics (25%) were least likely to report dental sealants.

Data on dental sealant utilization for children in the SCHIP program has been analyzed by the CT Voices for Children. For children age 6-15 continuously enrolled over the 2004 calendar year, 10% had at least one sealant placed. For those aged 15, only 4.8% had at least one sealant placed and for the age group 6 - 8, 18% had at least one dental sealant.

The Office has teamed up with the University of Connecticut School of Dental Medicine in planning a statewide clinical oral health survey to determine the oral health status of preschool and elementary school children using the CDC Basic Screening Survey (BSS). The CT Every Smile Counts will provide oral health prevalence data for Head Start, kindergarten and third grade children in Connecticut. The survey was planned for the fall of 2006 school year. An advisory committee was established to include epidemiologists from DPH, representatives from the State Department of Education, School Nurse Association, Dental Hygiene, Head Start and Local Health Administration. Information provided by the Advisory Committee on school and Head Start timetables and infrastructure was invaluable to the success of the survey.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a strategic plan for enhancing DPH data and information systems to improve the monitoring of dental sealants' prevalence				X
2. Continue OPENWIDE training of non-dental providers				X
3. Convene workgroup to address barriers/issues regarding billing of dental procedures in public health facilities				X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The Office conducted the CT Oral Health Basic Screening Survey, "Every Smile Counts," during the 2006-2007 school year. This is the first time that an open-mouth survey of the oral health status of CT children was conducted to include children in Head Start, kindergarten and 3rd grade from all eight counties in the state. 76 schools and 20 Head Start Programs participated in the survey with more than 10,000 children screened for dental sealants, untreated caries, treated caries, rampant caries (5 or more untreated teeth) and need for urgent care.

Collaboration was developed with UConn, the University of Bridgeport, School of Dental Hygiene and the Southwest AHEC to recruit and train the dental hygienists and recorders to conduct the survey. Funding from the MCHBG, the CT Health Foundation and the CT State Dental Association and Foundation supported this effort.

DPH obtained dental sealant data from the DSS for state fiscal year 2006. These data reflect the number of children in the HUSKY A Program with at least one dental sealant placed during that time. For children age 6-15 ever enrolled, 8.8% had at least one sealant placed. For those aged 15, only 4.0% had at least one sealant placed and for the age group 6-8, 13.1% had at least one dental sealant.

The Oral Health in Connecticut Report was finalized. The information contained in this document will facilitate the future monitoring of trends and improvements in oral health of Connecticut residents.

c. Plan for the Coming Year

The Office plans to develop an oral health status report of children in Connecticut based on the results from oral health basic screening survey (Every Smile Counts) conducted in the 2007 school year. Results will be analyzed by the eight regions of the state and statewide for Head Start, kindergarten and third grade children. The report will suggest opportunities to improve oral health of Connecticut children.

The OPENWIDE training curriculum for non-dental providers will be updated to include perinatal oral health information. The target populations will be expanded and will include not only Head Start and WIC personnel, but also day-care providers in both large facilities and home-based care programs. Volunteer trainers will be recruited for OPENWIDE, focusing initially on recruitment of dental hygienists trainers and will eventually include nurse/APRN and social services trainers.

Staff from the Office of Oral Public Health will be joining staff from the Family Health division on their annual site visits to School-Based Health Clinics and Community Health Centers to provide technical assistance and quality assurance review of dental operations. Staff, when requested, will also provide oral health education and information to non-dental providers in those sites that do not offer dental services.

A standardized oral health data collection tool will be developed. Currently Connecticut does not have any uniform methodology to collect and disseminate oral health data. This tool will be the model for oral health data collection in Connecticut. In addition, a database that correlates with the data collection tool will be available to facilities to enable and simplify standardized oral health data collection.

The Office will distribute a Request for Proposal (RFP) for available bonding monies to enhance oral health care by developing or expanding dental facilities for underserved populations.

Preference will be given to applicants that target high-risk populations such as WIC and Head Start children and their parents.

The FHS will collaborate with the Office of Oral Public Health on the HRSA, MCHB Targeted State MCH Oral Health Service Systems Grant Programs grant application. The proposed grant goals are consistent with those of CT's Early Childhood Partner's (states ECC grant) as well as the state Perinatal Health Plan.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	1	0.7	0.7	0.9	1.5
Annual Indicator	0.7	1.5	1.9	1.6	
Numerator	5	11	13	11	
Denominator	729316	734933	691876	682998	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	1.4	1.3	1.2	1.1	1

Notes - 2006

Source: CY2005 provisional data, CDPH, Vital Statistics is the most recent data available June, 2007. CY2006 data is expected to become available in 2008.

Notes - 2005

Source: CT Dept. of Public Health, HISR, CY 2005 provisional Vital Statistics. We do not anticipate having provisional 2006 data until a year from now.

Notes - 2004

Source: CY2004 Provisional Vital Statistics, CT Dept of Public Health

We do not anticipate having provisional 2005 data until a year from now.

The form would not allow modification of the 2005 objective now based on our newly acquired data for 2004. If we had the opportunity to adjust this figure our objective for next year's reporting would be 1.5 .

7/07 note: final 2004 Vital Statistics, CTDPH were rerun with a slight change in the data reflected here.

a. Last Year's Accomplishments

In 2004, there were 12 deaths due to motor vehicle crashes among children aged 14 years and younger, for a rate of 1.7 per 100,000. The annual performance measure objective of 0.7 per 100,000 was not met for 2004. Since 2000, the number of deaths in CT due to motor vehicle crashes in this population has varied from year to year (7 deaths in 2000, 7 in 2001, 5 in 2002, 11

in 2003). Over 25% of all deaths among 1-14 year olds are due to unintentional injury and 40% of these deaths are related to motor vehicles. Yearly, about 9,000 children 8 years and less are occupants of motor vehicles involved in crashes in CT (CT DOT Crash File 1996-2002). Crashes were responsible for approximately 150 inpatient hospitalizations among children age birth to 14 during 2004 (OCHA Hospital Discharge Data).

The Injury Prevention Program (IPP) and Safe Kids CT held 14 child passenger safety workshops for 200 healthcare and childcare professionals designed to provide accurate and effective education on child passenger safety issues. One workshop was a specialized 2-day training for certified child passenger safety technicians on safe transportation for CSHCN.

IPP, Safe Kids Coalitions and CT Dept. of Transportation (DOT) educated the public and professionals on CT's enhanced Child Passenger Safety Law (effective 10/1/05), requiring children to use a child restraint system (child safety seat, booster seat) until they reach 7 years of age and weigh 60 pounds regardless of age. They also partnered to prevent motor vehicle injuries among 4-8 year olds by increasing booster seat use. Data from DOT crash files indicate that 77% of children birth to 3 years involved in car crashes were in child restraints, while only 16% of the 4-7 years olds were in child restraints.

IPP and Crash Outcome Data Evaluation System (CODES) Project have been moved from the Family Health Section to the Health Education Management and Surveillance Section. CODES links motor vehicle crash reports with death, hospital, and emergency room data to provide a more comprehensive picture of motor vehicle related injuries and deaths.

DPH funds to local health departments for motor vehicle injury prevention programs focusing on child passenger and pedestrian safety.

Comadrona, HCWC and RFTS provide referrals and linkages so that infants and children served were properly secured when riding in a vehicle. HCWC provided car safety seats to clients who would not otherwise have been able to afford them. CHCs provided age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety. SBHC professionals routinely offered motor vehicle safety information to students in the form of one-on-one meetings as well as group sessions.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance, resources, and funding to support to motor vehicle injury prevention activities				X
2. Provide linkages to motor vehicle injury prevention resources		X		
3. Provide screening, risk assessment and anticipatory guidance in Title V funded programs	X			
4. Provide guidance and support for policy development regarding motor vehicle related mortality in children				X
5. Participate in statewide coalitions and collaborations addressing motor vehicle injury prevention through public and professional education, policy change and system enhancements				X
6. Utilize injury-related data to guide planning for state and community based programs and policy development				X
7.				
8.				
9.				

10.				
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b. Current Activities

The Injury Prevention Program (IPP), is planning a series 18 child passenger safety workshops for FHS contractors and other healthcare, childcare and community service providers. These will be conducted between April and September 2007. This year a special focus will be placed on providing training and resource materials for Healthy Start and Head Start Program staff and Health Consultants for child care programs.

One of MCHBG funded workshops will be Safe Travel for All Children, a specialized two-day training for certified child passenger safety technicians on safe transportation for CYSHCN.

IPP is collaborating with state and local partners including Safe Kids and the CT DOT to address motor vehicle injuries among children. There are several new initiatives lead by the DOT that may impact motor vehicle injuries and deaths among children including the CT Safe Routes to School Program and the state Pedestrian-Bicycle Advisory Committee.

IPP staff will present a session on injury prevention to the adolescent father's parenting group that is being conducted in collaboration with the Hartford Community Court. The session will include the use of car safety restraints as well as safety for infants in the home.

The CT CODES Project is working on linking motor vehicle crash and hospital/ED data. A CODES Advisory Board, including data owners and users, has been formed to help ensure that CODES data is used to develop and support motor vehicle injury prevention programs.

c. Plan for the Coming Year

The Injury Prevention Program will work closely with Family Health Section programs to integrate motor vehicle injury prevention into Title V and other children's programs throughout the Department including Day Care Licensing and Emergency Medical Services for Children. The Injury Program will continue to participate in the Virtual Children's Health Bureau to strengthen internal agency collaborations around childhood injury prevention.

The Injury Prevention Program will provide technical assistance to Family Health Section programs, contractors, and target populations on motor vehicle injury prevention issues. The Injury Program will continue to collaborate with Title V programs, CT Safe Kids Coalition, CT Department of Transportation and other partners on child passenger safety and other transportation safety issues that impact children.

The Injury Prevention Program will use CODES data in the development and support of programs and policies that address the risk factors for motor vehicle injuries among children and adolescents.

DPH funded case management programs for women and children will work more closely with Injury Program staff to enhance activities to reduce the death rate for children age 14 years and under caused by motor vehicle crashes. DPH will provide injury prevention materials to the state Healthy Start Programs.

SBHCs will continue to have motor vehicle safety as an integral focus of events and services. Community Health Centers, as EPSDT providers, will continue to provide children and/or their caregivers age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					36.8
Annual Indicator				36.8	38.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	39	39.5	40	40.5	41

Notes - 2006

Source: 2005 CDC's N.I.S. has a confidence interval of +/-5.9%. Data is from CY2005 NIS survey sampling.

Websource: www.cdc.gov/breastfeeding/data/NIS_data/data2005.htm.

Notes - 2005

This year NPM 11 measures breastfeeding at 6 months. The prior/retired breastfeeding measure NPM 11 showed data for breastfeeding at hospital discharge. Source: 2004 CDC's N.I.S. has a confidence interval of +/-5.8%. Data is from CY2004 NIS survey sampling with numerator and denominator derived from projections to DPH birth data. Websource: www.cdc.gov/breastfeeding/data/NIS_data/data2004.htm. Ross Laboratories "Mother's Survey" reports 35.3 for 2004. This falls within the confidence interval for NIS data.

a. Last Year's Accomplishments

The estimated rate of breastfeeding at 6 months of age in CT was 38.8% according to the 2005 National Immunization Survey (NIS), up from 33.1% in 2004.

DPH provided materials to Title V case management programs for pregnant women (HCWC, Healthy Start, Comadrona, RFTS) and informed them of continuing education opportunities. DPH also continued to provide English/Spanish breastfeeding information sheets for the packets mailed to all new mothers, and new consumer education materials were procured. An article regarding breastfeeding was developed by the DPH Breastfeeding Coordinator and published in a newsletter distributed to all childcare providers in the state. In celebration of World Breastfeeding Week in August, DPH displayed a promotional banner outside the State Office Building, participated in an event sponsored by the CT Chapter of the American Academy of Pediatrics and set up a display in a well traveled corridor at the office complex that houses DPH. A press release was distributed to the media to publicize the 2005 National Immunization Survey breastfeeding rates for Connecticut, to encourage mothers to breastfeed exclusively for at least six months and to connect the public to accurate breastfeeding information and help.

DPH collaborated with the CT Breastfeeding Coalition (CBC) by actively participating in monthly meetings and serving on the Board of Directors. The DPH Breastfeeding Coordinator attended the first National Conference of State Breastfeeding Coalitions, convened by the United States Breastfeeding Committee (USBC) in January 2006. In follow up to the conference, she led several planning sessions at CBC meetings to identify priorities for 2007. The Coordinator also

was a member of the CBC conference committee that planned the coalition's first full day conference, which was held in October 2006.

The CT Breastfeeding Initiative report was posted on the DPH website in September 2006. Recommendations included, but were not limited to: the use of peer education models, particularly at sites serving the women least likely to breastfeed; engaging Black churches and other Black institutions by recruiting and training church leaders to the benefits of breastfeeding; exploring sources of reimbursement for breastfeeding classes; the use of public information and mass media to reach specific audiences, and training of health care professionals.

The WIC Program promoted breastfeeding, with each local WIC Program having a designated Breastfeeding Coordinator. The breastfeeding initiation rate among WIC infants rose slightly to 57.7% as of September 30, 2006. However, only 7.5% of WIC infants were breastfeeding at 6 months of age. The WIC Program sponsored the attendance of another group of local WIC nutrition staff at the 40-hour Certified Lactation Counselor (CLC) course. USDA Breastfeeding Peer Counseling Program grant funds were used to continue to support the expansion of the Hartford-based peer counseling program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Attend and participate in the monthly CBC meetings				X
2. Identify and track breastfeeding data sources to further build infrastructure				X
3. Promote provider and consumer education and awareness through training and education				X
4. Implement recommendations of provider survey and consultant analysis of disparities in breastfeeding rates in African American women as appropriate				X
5. Promote and support the WIC Breastfeeding Peer Counseling Program		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Comadrona, HCWC, Healthy Start, RFTS and WIC provide education, support and referrals to mothers to initiate and maintain breastfeeding. DPH will display breastfeeding banner in August, Breastfeeding Awareness Month.

DPH is actively involved in the CBC, and 1st day-long CBC conference was held on 10/26/06 with over 160 attendees. The Results of the PRATS Survey was posted on CBC listserve and membership was invited to a 1/07 presentation. DPH Breastfeeding Coordinator serves as state proctor for bimonthly conference calls sponsored by the CDC and USBC. Information was provided to 2 state agencies to assist with their worksite breastfeeding support programs. The International Lactation Consultant Association's guidelines for infant feeding during emergencies and posters developed by Texas WIC Program regarding breastfeeding during emergency situations were provided DPH liaison to CT Department of Emergency Management and Homeland Security meetings.

The WIC Program maintains a small inventory of electric breast pumps that are issued to eligible

women who are returning to work or school. The WIC Program continues to fund the expansion of the Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program that is jointly administered by the Hispanic Health Council and Hartford Hospital.

c. Plan for the Coming Year

The DPH Breastfeeding Coordinator position will continue to be co-funded by MCHBG and USDA funds to assist the DPH in promoting and supporting breastfeeding. All DPH perinatal health programs will provide or refer clients to breastfeeding support services as integrated in their case management activities.

DPH will participate in monthly meetings of the CBC, as well as Board of Directors and conference committee meetings. World Breastfeeding Week and CT Breastfeeding Awareness Month activities will be planned and implemented. Consumer education materials will continue to be distributed via the Immunization Program's hospital discharge packets and other appropriate vehicles.

Activities initiated during FY 2007 in follow up to the recommendations in the Connecticut Breastfeeding Initiative report will continue, in an effort to address racial and ethnic disparities in breastfeeding rates and to improve access to breastfeeding information and support for all families.

Regarding the training of health care professionals, in addition to the second annual CBC conference, a peer-to-peer physician education initiative is being explored and plans are in process to promote the American Academy of Pediatrics breastfeeding residency curriculum. Finally, discussions are underway with the Connecticut Hospital Association to encourage the discontinuation of commercial infant formula discharge bag distribution to new mothers by its member hospitals.

Current WIC breastfeeding promotion and support activities will continue, and efforts to improve the breastfeeding duration rate will be emphasized. The expansion of the Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program that is jointly administered by the Hispanic Health Council and Hartford Hospital will continue to be funded. Additional funds will be sought to replicate the BHP model in other communities.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	95	97	99.9	98.2	99
Annual Indicator	96.9	100.0	98.0	98.9	99.0
Numerator	41347	41852	41696	41696	41744
Denominator	42655	41868	42545	42142	42147
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2007	2008	2009	2010	2011
Annual Performance Objective	99.1	99.2	99.3	99.4	99.3

Notes - 2006

Source: CTDPH, CY2006 Provisional E.H.D.I. Program, Family Health Section

Notes - 2005

FFY2005 births and CT Early Hearing Detection and Intervention System. The newborn screening program started in 2000.

Notes - 2004

CY2004 CT Newborn Screening Program data matched with EVRS and AVIS system. The newborn hearing screening program started in 2000.

This year's goal (i.e. Annual Performance Objective) of 99.9 is based on the prior year's experience (i.e. "Indicator") of 99.9 which was rounded up to 100 as a function of the TVIS' programming. Therefore note that we did not predict a decline in our goal/experience from one year to the next.

a. Last Year's Accomplishments

In 2006, CT met its objective for PM #12 by ensuring 98.9% of newborns were screened for hearing loss. Tracking continues and provisional rates will improve once final 2006 diagnostic data is available. The average of age at diagnosis was 2.6 months and age at referral to early intervention (EI) was 4.23 months. Infants with a bilateral, 40 dB or greater hearing loss, or auditory neuropathy are automatically eligible for EI services in CT through the Birth to Three System. Of the 64 infants diagnosed with a hearing loss, 35 were eligible for EI services, 25 were enrolled, and 1 expired. There were no refusals. CT implemented the Listen and Learn program to provide monitoring for infants with a mild or unilateral hearing loss hearing loss, who were not eligible for EI services. The program offered children a free speech and audiological evaluation every six months and empowered parents through education and advocacy. Of the nine infants enrolled in Listen and Learn, two were found to have a progressive hearing loss and were subsequently eligible, and enrolled in EI.

Enhancements were made to the Early Hearing Detection and Intervention Program (EHDI) database, including a link to the electronic birth certificate. These modifications improve reporting, tracking and program evaluation capabilities.

Provider education efforts included Grand Round presentations at CT hospitals and the development of a web-based training titled, "Newborn Screening in CT." The training featured the state's foremost experts on genetic, metabolic and other disorders included in the newborn screen and offered free continuing education credits and nursing contact hours. The target audience was pediatric health care providers.

Family education efforts include the development of a brochure for families titled, "What Parent's Should Know About Genetics Testing and Evaluation of Babies with Hearing Loss". The diagnosing audiologist will distribute the brochure and it is available in English and Spanish.

The DPH Commissioner recognized the CT American Academy of Pediatrics Chapter Champion, Dr. Antonia Capriglione, for her six years of service to the EHDI program and a new Chapter Champion was appointed.

CT participated in the National Center for Hearing Assessment and Management's Early Childhood Hearing Outreach project and provided hearing screening training to three Early Head Start programs. A total of six Early Head Start programs in CT now have the training, equipment and technical support to conduct hearing screenings on enrolled children. The American School for the Deaf is now the lead agency for this project.

DPH provided funding to four neonatal intensive care units to purchase automatic brainstem response (ABR) screening equipment to facilitate ABR screening among high-risk infants before discharge, consistent with state guidelines.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve state data tracking system				X
2. Improve follow-up on missed or abnormal screens				X
3. Improve follow-up on infants lost to diagnostic follow up				X
4. Improve tracking on follow-up program for infants at risk for hearing loss			X	
5. Educate primary care providers on genetic factors associated with hearing loss				X
6. Distribute culturally sensitive educational materials to parents			X	
7. Assure linkage to a medical home		X		
8. Hire support staff to assist with tracking and follow-up				X
9.				
10.				

b. Current Activities

In January 2007, Newborn Screening staff presented at the annual Nurse Midwives Association meeting to reinforce the importance of timely newborn lab and hearing screenings. EHDI staff assisted a large home-birth practice to acquire donated hearing screening equipment from a local hospital and will begin collecting hearing screening data on this population once staff are trained.

The CT EHDI Task Force was instrumental in encouraging the CT Birth to Three System (IDEA, Part C) to expand their eligibility requirements to include children with mild and /or unilateral hearing loss. The proposed budget option was recently approved by our Governor and will take effect July 1, 2007. DPH staff meets monthly with the EHDI Task Force to discuss issues relevant to infant hearing, early identification and habilitation, and meets quarterly with the Commission on Deaf and Hearing Impaired Advisory Board.

The EHDI program conducted site visits to nine birth hospitals and provides ongoing technical assistance to screening and diagnostic staff as needed via telephone and e-mail.

In May 2007, the DPH sponsored a conference for audiologists titled, "Sound Foundations for Infants and Children with Hearing Loss." The agenda included education on the latest advances in audiology as well as best practice models for diagnostics, sedation, referrals to specialists, family education and support.

c. Plan for the Coming Year

Audiologists, family practitioners, obstetricians and pediatricians will be educated on issues relative to genetics and hearing loss through meetings, web-site information and written materials. The DPH will conduct a one-day educational conference for diagnostic testing center and other audiologists to discuss issues relevant to infant hearing loss, early hearing detection and intervention, reporting results to DPH, and other related topics.

Geneticists from the University of CT and Yale University School of Medicine will conduct Grand Round presentations at area hospitals to educate providers on newborn screening and Genetics. EHDI staff will continue to promote the web-based training for providers titled, Newborn

Screening in Connecticut" to increase their knowledge about testing, tracking and treatment of disorders screened for in the CT Newborn Screening panel.

The EHDI program will sponsor a one-day educational conference for hospital staff in an attempt to increase their knowledge of newborn screening, infant hearing loss, risk indicators, late onset and progressive hearing loss, communicating results to families, the diagnostic referral, and tracking and follow-up.

Informational materials will be sent to obstetricians to increase their awareness about congenital hearing loss and the benefits of early hearing detection and intervention.

Educational materials will be developed for parents of infants identified with risk factors for hearing loss, who pass the newborn screening but require ongoing monitoring. The information will be shared with families and health care providers to increase awareness about monitoring for late onset or progressive hearing loss.

Program staff will conduct a family survey to assess the satisfaction level with the program and to identify areas in need of improvement. The survey results will be shared with the birth hospitals and diagnostic testing center staff.

Plans will be established to develop a parent support network for families of newborns and children identified with hearing loss. EHDI staff will participate in the National Center for Hearing and Rehabilitation's "Investing in Family Support" conference.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	4.8	4.5	4.4	4.4	8.4
Annual Indicator	4.5	4.7	4.5	8.5	8.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	8.2	8.1	8.1	8	7.9

Notes - 2006

Source: CPS Table HI05, US Bureau of the Census, 2005

Notes - 2005

This year's data source with target population has changed. Prior years reflected a 3 year average for the poverty population. This year's percent refers to the entire CT pediatric (<18) population. Source: US Bureau of the Census, Current Population Survey, Table HI-5, 2004.

Notes - 2004

Source: US Bureau of the Census, Current Population Survey based on three year rolling averages, 2003.

a. Last Year's Accomplishments

Data for Health Insurance Coverage for Connecticut comes from the US Census Bureau. The most recent data from the Current Population Survey, 2004 Annual Social and Economic Supplement, Table HI-5 reports that 8.5% of all of Connecticut's children under age 18 had no health insurance in that year. However, the population referenced in the source table is expanded from prior years' focus on low-income children and now includes all children in the state. The projection for this year of 4.4% related just to children under 200% of the Federal Poverty Level is therefore not applicable.

A review of the last five years shows that this percent in CT has worsened over time with an increase of uninsured children from 6.8% in 2000 to 8.5% in 2004. The U.S. over the same period showed a reduction in the percent of children uninsured, starting at 11.9% in 2000 reducing to 11.2% in 2004.

Recent CT trends in diminishing health insurance coverage for employed persons and families of any income have made it clear that the Title V program needs to be concerned with all children and not just those of low income families. Interestingly, the percentage of uninsured in the lowest income strata has been decreasing reflecting successful outreach of the state's SCHIP program (called HUSKY in CT) to this segment of the population.

Right From The Start, Comadrona, Healthy Start, Family Planning, School Based Health Centers, Community Health Centers, Healthy Choices for Women and Children, Regional Medical Home Support Centers and WIC screened families for insurance, provided support, information and linkages to health care insurance coverage for children.

The CT Infoline-211 provided presentations and training to community-based providers, agencies, and groups to encourage enrollment in the HUSKY program. The program provided 24 hours/7 days a week toll-free telephone access to information and referral for maternal and child health issues, including access to insurance programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, screening and referral to sources of health insurance		X		
2. Provide advocacy and liaison to assist families in obtaining health care coverage		X		
3. Provide education regarding resources to consumers and community-based providers				X
4. Support the state's information and referral services as a point of access for insurance coverage			X	
5. Provide follow-up and assistance with insurance application process		X		
6. Develop capacity with local organization as resources for outreach and enrollment				X
7. Provide education regarding resources to consumers and community-based providers				X
8.				
9.				
10.				

b. Current Activities

Right From The Start, Comadrona, Healthy Start, Family Planning, School Based Health Centers, Community Health Centers, Healthy Choices for Women and Children, Regional Medical Home Support Centers and WIC screen families for insurance, provide support, information and linkages to health care insurance coverage for children.

The State Perinatal Advisory Committee met to begin discussions of the State Perinatal Health Plan and its objectives. They identified as one of its goals the need to improve access to a continuum of health care services for underserved and/or unserved women of child-bearing age. The development of this goal has implications for improved birth outcomes and will assist in identification of insurance for infants as well as their mothers.

Infoline-211, the state's toll free MCH Information and Referral service, provides callers with information regarding HUSKY health insurance. Infoline staff also provides consumers and health care providers with education on HUSKY related issues.

DSS proposed legislation to fund outreach workers in schools to increase HUSKY enrollment. However, the legislation did not pass.

c. Plan for the Coming Year

Healthy Start, Family Planning, Community Health Centers, Healthy Choices for Women and Children, Regional Medical Home Support Centers and WIC will continue to screen families for insurance, and provided support, information and linkages to health care insurance coverage for children. Right From the Start and Comadrona programs will continue for the first half of the year and then funding will be consolidated and sent out to competitive bid for case management for pregnant women and teens. It is anticipated that this new program will screen families for insurance, and provide the same support, information, and linkages to health care insurance coverage for children.

The Perinatal State Health Plan identified as one of its goals the need to improve access to a continuum of health care services for underserved and/or unserved women of child-bearing age. The development of this goal has implications for improved birth outcomes and will assist in identification of insurance for infants as well as their mothers.

Infoline will provide MCH information and referral services including access to insurance, and will also provide presentations and training to community- based agencies and groups regarding the HUSKY Program.

SBHCs are considering a proposal to study uninsured elementary students to estimate the prevalence of the problem of lack of insurance, identify best practices to increase insurance enrollment, and develop recommendations regarding SBHC's practices to enroll more families in HUSKY.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					23.9
Annual Indicator				24.0	9.2

Numerator				7143	2709
Denominator				29729	29481
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	9.2	9.1	9	8.9	8.8

Notes - 2006

Source: CTDPH, WIC Program, SWIS monthly report on risk factors, Jan. 2007 (Children's BMI between 85 and 95%).

Notes - 2005

This measure changed, so this is the 1st year we're reporting this data. The percent reported is a BMI approximation from the January 2006 monthly SWIS report, CT WIC program.

a. Last Year's Accomplishments

Being the first year CT is reporting this data, the baseline percent for this reporting period is a BMI approximation from the January 2006 monthly Statewide WIC Information System (SWIS) nutrition risk factors report. There are 17 local WIC agencies, 21 permanent WIC sites, and over 50 WIC satellite sites throughout Connecticut serving WIC participants. Based on the report, 59,401 participants were enrolled in the WIC program, 29,729 of which were children 1-4 years of age. Of these 29,729 children, 7,143, or 24.1%, were determined to have a BMI approximation at or above the 85th percentile.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Automate WIC database to generate BMI				X
2. Training of WIC providers in using BMI				X
3. Meet with CHCs re: BMI and nutritional services				X
4. Support the No Child Left Inside campaign			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

There are 17 local WIC agencies, 21 permanent WIC sites and over 50 WIC satellite sites in CT. Based on the January 2006 Statewide WIC Information System (SWIS) nutrition risk factors report, 61,814 participants were enrolled in the WIC program, 30,582 of these were children ages 1-5, and 16,620 were 2 to 5 years of age.

The September 2006 BMI data for children 2 to 5 years of age was as follows: 913 (5.5 %) had a BMI > 85% and < 95% percentile (classified at risk of overweight); 964 (5.8 %) had a BMI > 95% percentile (classified as overweight); and Combined, 1877 (11.3 %) were at risk of overweight or

overweight.

The September 2006 data should be considered "tentative" baseline data for BMI in the CT WIC Program and cannot be compared to last year's weight/length data used for the NPM # 14 for children 1 to 5 years of age for the following reasons: (1) Last year's data set and this year's data set are derived from two different anthropometric measurements and two different age ranges. Last year's data included 1-5 year olds and was based on weight/length. This year's data includes 2-5 year olds and measures BMI, which is not equivalent to weight/length; (2) The September SWIS NRF 2006 report results for BMI overweight and at risk of overweight rates seem lower than expected.

CHCs collect height and weight information on all well child care visits and provide screenings for WIC eligibility. Culturally appropriate nutritional counseling is offered to families as needed.

c. Plan for the Coming Year

BMI will be calculated automatically into the Connecticut WIC Program computer database and available as the growth/weight database tool for WIC participants 2-4 years of age. Training on the use of BMI has been provided to all local WIC nutritionists and additional follow-up training is planned for fiscal year 2008 and WIC staff will follow-up with high-risk children in accordance with WIC policy.

Staff will meet with the CHCs and determine the BMI information collected on children 2-5 years of age and extend to nutritional services provided to families.

DPH will partner with the Department of Environmental Protection on the expansion of the "No Child Left Inside" program.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					3
Annual Indicator				3.1	0.2
Numerator					89
Denominator					41086
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	0.2	0.2	0.1	0.1	0.1

Notes - 2006

Source: CY2005 provisional data, CTDPH, Vital Statistics Note: the teen mothers' rate of smoking for this same time period was more than twice this rate i.e. 0.5. Note also: the form did not allow access to the column labelled 2005 which is the actual time period of this newly

available data. CY2006 data will become available in 2008.

Re:2005 column

7/07 note: The TVIS has locked this column. Final 2004 data just run has yielded a slight change in this percent i.e. 3.0 resulting from 79/2631.

Notes - 2005

Source: CT Dept of Public Health, Vital Statistics CT2004 provisional. This measure changed with the new guidance, so prior year's data are irrelevant.

a. Last Year's Accomplishments

Connecticut's data source for this performance measure is from Vital Statistics, for which CT collects information on smoking during pregnancy. CT does not collect data specifically on smoking in the last trimester. For 2004, 3.1% of women reported smoking during their recent pregnancy. Alternate data sources exist for future years of data collection.

The CT Quitline is a tobacco cessation counseling and referral telephone helpline available to all CT residents. The CT Quitline collects information on pregnancy status. In 2006, of female callers who were tobacco users, 5.71% were currently pregnant, and 4.05% were planning a pregnancy in the next 6 months.

The Title V-supported programs Healthy Start, Right From the Start, Comadrona and Healthy Choices for Women and Children screened women for smoking during pregnancy, provided counseling for need to stop and referred clients to smoking cessation programs. Screening took place upon entry into the program that was focused on a time when pregnancy is confirmed and preferably during the first trimester.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide cessation counseling and referral through the CTQuitline	X			
2. Educate health care professionals and providers in cessation intervention and treatment				X
3. Educate public about the effects of tobacco use and secondhand smoke			X	
4. Screen and refer women to smoking cessation programs		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CT Quitline continues to counsel and refer CT residents about tobacco use cessation. Quitline promotion packets for health care providers were mailed to all community health centers, school based health centers, family planning sites and WIC clinics. These packets include CT Quitline information, fact sheets, Quitline referral prescription pads and a provider fax referral sheet. The provider can fax this referral sheet directly to the Quitline, that in turn, contacts the patient directly.

The Tobacco Control program awarded two community grants to local agencies working with pregnant and postpartum women in addressing secondhand smoke and cessation. These

programs are the American Lung Association of CT (ALA) in partnership with Yale-New Haven Hospital's Woman Center and the City of Meriden Health Department. The Meriden Health Department has developed a support group for pregnant and post partum women from the WIC clinic who have quit smoking. ALA is conducting educational programs through the nurses to clients which address second hand smoke and promote quitting.

The Title V-supported programs Healthy Start, Right From the Start, Comadrona and Healthy Choices for Women and Children continue to screen women for smoking during pregnancy, provided counseling for need to stop, and refer clients to smoking cessation programs.

c. Plan for the Coming Year

The Quitline is funded until 2008 and will continue providing cessation services. Conferences and workshops are scheduled to address cessation and the treatment of tobacco dependence. The Title V-supported programs Healthy Start and Healthy Choices for Women and Children will screen and counsel women for smoking. New case management programs for pregnant women will include the promotion of smoking cessation. In addition to screening women upon entry, usually during the first trimester, programs will address the need to screen again during the 3rd trimester. Findings from the screenings will be compared to determine the number who entered and successfully completed a smoking cessation program. Plans will be developed to mail Quitline packets to relevant Title V programs.

DPH has been awarded funds to provide Nicotine Replacement Therapy to callers to the CT Quitline. This funding will be available until 2008.

DPH will partner with the Department of Social Services to market the Quitline services to their Medicaid participants and providers.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	9.2	5.6	5.6	2.5	2.5
Annual Indicator	5.6	2.6	2.9	4.0	
Numerator	13	6	7	10	
Denominator	230667	234895	241182	247415	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	3.8	3.6	3.4	3.2	3

Notes - 2006

Source: CT Dept of Public Health, Vital Statistics CY2005 is the most recent data available in June 2007. CY2006 data are not expected to be available until 2008.
 Note: The 2006 objective was not able to be changed in light of the most recent data. It is locked by the form at 2.5 when we would have liked to change it to read 3.9.

Notes - 2005

Source: CT Dept of Public Health, Vital Statistics CY2005 is the most recent data available in June 2007. CY2006 data are not expected to be available until a year from now. Denominator represents DPH 2005 population estimates (HISR, Backus & Mueller).
 Note: The 2006 objective was not able to be changed in light of the most recent data. It is locked by the form at 2.5 when we would have liked to change it to read 3.9.

Notes - 2004

Source: CT Dept of Public Health, Vital Statistics CY2004 data are not expected to be available until a year from now. The 2.5 rate represents what we would like to change the 2004 annual performance objective goal to read based on our most recent experience i.e. 2003 data. This field is "locked" by the TVIS form's programming at what we entered last year based on 2002 experience.

a. Last Year's Accomplishments

Suicide rates among Connecticut youth aged 15 through 19 are unstable because of the relatively small number of deaths. In 2004, the suicide rate was 2.9 in 100,000 (CT Vital Statistics). In Connecticut, 15.1% (+ 2.1%) of high school youth completing the Youth Risk Behavior Survey (YRBS) said that they seriously considered attempting suicide (YRBS 2005).

Both Title V and non-Title V programs provided services to adolescents with the goals of improving mental health, facilitating appropriate referral and reducing suicidal thoughts and actions among high school youth.

SBHCs provided comprehensive mental health services to enrolled students at all sites. SBHCs have policies and procedures in place that address center-specific protocols for handling youth with suicidal thoughts and attempts. During the 2004-2005 school year, mental health-related care encompassed 31.6% (28,146) of all visits to SBHCs. This is a slight decrease from the previous year where 33.5% of the visits were mental health related. They continue to assure these mental health services through direct provision of care via on-site clinicians such as social workers, psychiatrists and psychologists and through referrals to community agencies such as local hospitals, child guidance centers and mental health centers. SBHCs conducted health education sessions on violence prevention, stress, self-esteem, healthy relationships and grief/bereavement.

Infoline, Connecticut's information and referral service, provided 22 suicide prevention presentations and training to providers, agencies, community groups and students in the state. Community Health Centers (CHC) provided mental health services through screening, assessment, direct care and/or referrals. Healthy Choices for Women and Children (HCWC) provided comprehensive assessment of clients (39 women), including the need for mental health services. This program continued to identify and refer clients who are at risk for suicide to appropriate resources. Right From the Start (RFTS) provided a comprehensive assessment of clients (288 teens), including the need for mental health services. Referrals were made as necessary.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide suicide prevention training to students				X

2. Provide suicide prevention training to providers and other adults				X
3. Provide technical assistance and guidance for MCH programs				X
4. Provide anticipatory guidance and risk assessments in Title V funded programs, especially SBHCs		X		
5. Provide mental health services through assessment, direct care and/or referrals in SBHCs, CHCs and other MCH programs	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHCs provide mental health services through assessment, direct care and/or referrals. They continue to assure these mental health services through direct provision via onsite clinicians such as social workers, psychiatrists and psychologists and through referrals to community agencies such as local hospitals, child guidance centers and mental health centers.

SBHCs provide anticipatory guidance and mental health risk assessments at all locations. Other mental health services include crisis intervention, individual, family, and group counseling and referral and follow-up for specialty care. All SBHCs offer services directed at high-risk populations, such as youth with suicidal thoughts/attempts. Thirty-five individual SBHC mental health clinicians received Master Therapist training funded by DPH. Clinicians may opt to attend workshops covering diverse mental health issues. A total of 52 workshops were funded this year and 26 therapists attended a workshop on bipolar disorder in adolescents.

RFTS, HS and Healthy Choices for Women and Children provide comprehensive assessment of clients, including the need for mental health services. Referrals are initiated as necessary. These programs identify and refer clients who are at risk for suicide to appropriate resources.

The Injury Prevention Program provided technical assistance and guidance related to suicide prevention and other intentional injury issues to other DPH program staff.

c. Plan for the Coming Year

The program activities presented in the Current Activities section will be continued into FY06 with the continued goals of improving mental health, facilitating appropriate referral and reducing suicidal thoughts and actions among adolescents.

School Based Health Centers will provide anticipatory guidance, risk assessments and mental health therapy at all locations. Staff will work with SBHCs to enhance data collection tools related to mental health service delivery at SBHCs.

The new case management program for pregnant women and teens will include screening for perinatal depression. This program will be implemented in January 2008. Perinatal depression screening will be implemented in the state Healthy Start programs that provide case management services for pregnant women (and teens) at or below 185% of the FPL.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	83.1	87.5	87.5	87.5	87.3
Annual Indicator	87.5	87.4	87.1	87.1	
Numerator	580	557	575	580	
Denominator	663	637	660	666	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	87.4	87.5	87.6	87.6	87.7

Notes - 2006

Source: CY2005 provisional data, CTDPH, Vital Statistics is the most recent information available in June, 2007. CY2006 data are expected to be available in 2008.

Notes - 2005

Source: CY2005 provisional data, CTDPH, Vital Statistics. The facilities included in this measure are eleven hospitals with self-reported NICU's as reported to the state Office of Health Care Access. CT does not currently have ACOG "high risk" level certification/recognition system in place for its hospitals.

Notes - 2004

2004 data not available now, anticipated a year from now.

a. Last Year's Accomplishments

In 2005, 87.1% of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates. This percentage was a slight decrease from 87.4% in 2004. Connecticut did not meet its proposed objective of 87.5%. Title V perinatal programs, such as Right From the Start, Healthy Choices for Women and Children, and Healthy Start provided screening for early identification and referral of teens and women identified with high risk pregnancies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, identification and referral of high-risk pregnant teens		X		
2. Provide intensive case management and supports to promote positive pregnancy outcomes		X		
3. Provide culturally competent and linguistically appropriate care to high-risk populations	X			
4. Collaborate with tertiary care centers that provide specialized delivery and neonatal care				X
5. Collaborate with the members of the State Perinatal Health Advisory Committee to implement the plans goals and objectives				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities

CT has 30 birthing hospitals statewide and one birthing center located in Danbury, CT, contiguous to the NY. There are 11 "self-defined" Level III Neonatal Intensive Care Units in CT.

DPH reconvened the Perinatal Advisory Committee that developed the first Perinatal State Health Plan. The committee consists of representatives of: The Connecticut Hospital Association, The Community Foundation of Greater New Haven, University of Connecticut Health Center, Planned Parenthood of Connecticut, CPCA, Departments of DCF and DSS, Permanent commission on the Status of Women, The Women's Health Consortium, and CT Chapter March of Dimes. One of the recommendations in the plan identifies the need to reduce pregnancy and birth related risk factors by facilitating maternal transfers to tertiary perinatal/neonatal centers for high-risk antepartum, intrapartum and postpartum care.

The Title V-funded programs Comadrona, Healthy Start, Right From the Start, and HCWC provide outreach, screening, intensive case management, and referral for high-risk pregnant women to specialists and tertiary care centers. Through a case management approach, women identified as at-risk are referred for appropriate evaluation. Programs, such as Comadrona, provide focused outreach, risk assessment and case management services to pregnant women who, by virtue of cultural and linguistic barriers, have difficulty obtaining needed care. These women are referred to culturally appropriate health and related social services.

c. Plan for the Coming Year

Healthy Start, Family Planning, Healthy Choices for Women and Children and Community Health Centers will assess and refer high-risk pregnant women to facilities for high-risk deliveries and neonates. Funds from the Right from the Start and Comadrona programs will be merged and a Request for Proposal submitted to create a new program to promote case management for pregnant women and teens; this program will continue to provide outreach, screening, case management and referral for high-risk pregnant women to specialists and tertiary care centers.

The State Perinatal Health Advisory Committee (which is now part of the Infoline MCH Advisory Committee) will continue to meet and recommendations from the Perinatal State Health Plan that impact this measure will be reviewed and implemented, as resources are available.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective	88.9	88.8	88.9	88.9	87.8
Annual Indicator	88.5	88.8	87.2	86.7	
Numerator	36358	37454	36090	35654	
Denominator	41080	42176	41392	41103	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	87	87.3	87.6	87.9	88.2

Notes - 2006

Source: CY2006 provisional data is expected to be available in 2008.

The objective field here is locked and not able to be changed as we would like to 87.0 i.e. a more reasonable projection based on a two-year downward trend.

Notes - 2005

Source: CT Dept of Public Health, Vital Statistics CY2005 Provisional is the most recent year of data available in June 2007. CY2006 Vital Statistics provisional data are expected to be available in 2008.

The 2006 Objective field is locked by the form and not subject to change. We would have liked to change this to a more realistic projection based on two years' downward trend i.e.87.0 rather than 87.8

Notes - 2004

Source: Provisional CY 2004 Vital Statistics data, CT Dept of Public Health.

7/07 note: final CY 2004 data just run resulted in a slight change in the denominator and resulting percentage which is reflected in this data now.

a. Last Year's Accomplishments

In CT in 2004, 87.5% of infants were born to woman who began receiving prenatal care in the first trimester, which was a slight decrease from the 2003 figure of 88.8%. Connecticut did not meet its projected goal of 88.9%.

Title V programs Comadrona, Healthy Start, Healthy Choices for Women and Children, Fetal Infant Mortality Review and Right From The Start and Right From the Start provided outreach to and identification of pregnant women to promote early entry into prenatal care. Programs not fully funded by the MCH block grant including Family Planning, School Based Health Centers, Community Health Centers and WIC, also promoted early entry into prenatal care.

The Pregnancy Risk Assessment and Tracking System (PRATS) survey is an 88 question survey designed to identify risk factors associated with adverse pregnancy and birth outcomes. The second round of the survey, conducted in 2003, was mailed to 4500 [recent] postpartum women in CT. The response rate (44.2%) was lower than desired, and results could not be generalized beyond the survey respondents. However, survey findings were consistent with DPH Vital Statistics data. Overall, 6.2% of women received late or no prenatal care. Black and Hispanic women were 2-3 times less likely to enter prenatal care (PNC) in the first trimester compared to Whites, and were less likely to have received PNC as early as desired. Women were asked about different barriers that may have prevented them from receiving care as early as desired. Not knowing they were pregnant, inability to schedule an appointment early in pregnancy, and not having enough money or insurance to pay for PNC visits were among the more frequently reported barriers. A report of the findings from Round 2 of PRATS was released this year, and made available to interested parties via the DPH website.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Provide outreach and case management to identify and enroll clients in early prenatal care		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services	X			
3. Provide outreach to targeted populations (i.e. pregnant substance users)		X		
4. Provide support, information and advocacy to pregnant teens		X		
5. Continue to analyze and disseminate PRATS Survey data			X	X
6. Provide pregnancy testing, reproductive health education, counseling and linkage to healthcare providers	X			
7. Develop a statewide fetal and infant mortality surveillance program			X	X
8. Promote early enrollment into prenatal care as a linkage from programs such as WIC		X		
9. Provide/promote comprehensive services to encourage women of reproductive age to enter prenatal care early		X		
10.				

b. Current Activities

Comadrona, Healthy Start, HCWC, RFTS, Family Planning, BHCs, CHCs and WIC use its community-based networks to identify and refer women for early prenatal care.

FIMR is implemented in five communities in CT. The FIMR process uses a confidential record abstraction and maternal interviews to identify mortality related issues including late entry into prenatal care. It is anticipated that the five FIMR contracts will be phased out after June 30, 2007. Starting in July 2006, the FIMR Program began a transition to statewide mortality review through an MOA with UCONN. This will allow fetal and infant data to be collected statewide and include data from urban areas (Bridgeport, Waterbury, etc.) that were not part of the previous FIMR activities.

The newly developed state added performance measure # 6 will allow CT to more effectively address the racial and ethnic disparities that were identified as part of the five-year needs assessment that impacts this measure.

Results from Round 2 of the CT PRATS survey were presented to DPH staff, external partners, and stakeholders. Staff also filled multiple requests for data resulting from the survey. Due to several limitations of the data from Rounds 1 and 2 of PRATS, further analytic analyses were not pursued. Rather, data have been used to compliment existing data and to begin plans for Round 3 of the survey, which is currently planned to begin in 2009.

A Health Disparities workgroup was convened to address the issue of health disparities.

c. Plan for the Coming Year

WIC, Healthy Start, Family Planning, School Based Health Centers, Healthy Choices for Women and Children and Community Health Centers will continue their efforts as described in the Current Activities section by encouraging early entrance into prenatal care. Funds from the Right from the Start and Comadrona programs will be merged and a Request for Proposal submitted to create a new program to promote case management for pregnant women and teens; this program will continue to provide outreach to identify women for early entry into prenatal care. The Fetal Infant Mortality Surveillance program will be implemented on a statewide basis and provide information about entry into prenatal care.

Data obtained under the newly developed state added performance measure #6 will allow CT to

more effectively address the racial and ethnic disparities that were identified as part of the five-year needs assessment which impacts this measure.

Epidemiology Unit staff will continue preparations for Round 3 of the CT PRATS survey. This work will include refining the sampling plan based upon analyses of respondents versus non-respondents from the previous 2 surveys; identifying an appropriate birth cohort and drawing the sample; finalizing survey content; and releasing an RFP to identify a contractor to administer the survey. Data from Round 3 will be used to identify and further investigate important factors related to seeking and accessing early prenatal care.

D. State Performance Measures

State Performance Measure 1: *Cumulative number of datasets incorporated into integrated warehouse (called HIP-KIDS).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					3
Annual Indicator				2	2
Numerator				2	2
Denominator	7	7	7	7	7
Is the Data Provisional or Final?				Final	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	2	5	6	7	7

Notes - 2006

Data is supplied by DPH staff working on the HIP-KIDS project. Two of the seven databases were incorporated into the data warehouse in 2005. There were no new additions in 2006.

Notes - 2005

Data is supplied by DPH staff working on the HIP-KIDS project. Two of the seven databases were incorporated into the data warehouse in 2005.

a. Last Year's Accomplishments

This object was successfully met. Scientific Technologies Corporation (STC) Inc., the contracted group hired to develop the technical strategic plan for HIP-Kids, completed their contract in September 2005. The resulting three-year technical strategic plan now serves as a blueprint for implementation of the HIP-Kids database. DPH staff attended a training session at the State of Missouri Department of Health to modify its web-based query system for access to aggregated data from HIP-Kids. CT's query system is called CHIERS. Staff participated on the Data Committee within the Virtual Child Health Profile.

Within FHS, improvements to the Child Health Profile (CHP) database were performed that complement the efforts to further the implementation of HIP-Kids. A consultant working on the CHP database, made the following enhancements: (1) Refinements to the matching criteria between newborn hearing screening results and birth records, yielding a 99.7% success rate (up from a 94%-95% success rate in earlier matching routines). Implementation is 100% complete. (2) Infrastructural work needed to integrate death records into the CHP database, in collaboration with Vital Records staff. The matching routine to find corresponding birth and/or CHP records to the death records was partially developed. Implementation is about 35% complete. (3) A front-end for the CHP was created so that select users within DPH can produce detailed statistics for the CHP database. This has greatly improved the ability to produce data for programmatic use

and statistical reporting, including reporting to the MCHBG. Implementation is 100% complete. (4) An assessment of future databases was performed to determine the next database for linkage with the CHP. Two specific possibilities are newborn screening results and the state's Immunization Registry. Newborn screening data reside within FHS, and the Immunization Registry resides within the Infectious Disease Section of the Department. Hardware and software upgrades are in process for both databases. (5) Staff was approached by the Environmental Public Health Tracking (EPHT) program to participate in their grant efforts to implement a statewide network that includes comprehensive noninfectious disease data. The databases under consideration for HIP-Kids implementation match well with the types of data EPHT is seeking to include in the statewide network. Planning began to identify and complete common linkages needed for HIP-Kids and EPHT. (6) Although not completed, linked child health data from the two disparate databases performed in the previous year (newborn hearing screening results, and birth records) are being linked to a third disparate database (death records).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Development of CHIERS, a web-based customized querysystem for child health data				X
2. Pursue funding for HIP-Kids project				X
3. Link Death Records to the growing Child Health Profile				X
4. Continue to participate on the Department-wide DataCommittee				X
5. Assess existing child health databases for inclusion into theChild Health Profile				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Work towards the creation of HIP-Kids continued. Funding from the EPHT program was obtained, and these funds are being used to implement a statewide network that includes comprehensive noninfectious disease data. The first significant step of this process is to migrate current databases to a single platform. This is planned for the CHP, pending sufficient funds. In the meantime, enhancements continue on the CHP. Work towards the addition of a third database to the linkage between the CHP and birth records continues, with a focus on death records. Also, enhancements have been made to the CHP to allow front-end reporting of data.

In collaboration with the Office of Health Care Quality, Statistics, Analysis and Reporting, work toward the implementation of CHIERS continues. A prototype of CHIERS (Connecticut Health Information Electronic Reporting System) is nearly complete. When made available to the public within the next few months, it will allow access to aggregated data on health-related topics in the state. The prototype will contain information on births, initial newborn hearing screening results, childhood lead screening results, and resident population. The tool is modeled after MICA, which was created and is maintained by the Missouri Department of Public Health. Development of CHIERS was made possible by a training opportunity offered by the Missouri DPH, and in collaboration with staff there.

c. Plan for the Coming Year

The FHS has continued its work with EPHT staff to further progress towards integrating child health databases into HIP-Kids. Certain requirements under the EPHT grant necessitated a slight modification to the original work plan. The order in which the core databases will be integrated has changed slightly, and the integration of death records has been pushed back.

Scientific Technologies Corporation (STC) is the consultant hired to complete the development and implementation work under the EPHT grant. Before data linkages can continue, several steps must occur. The first significant step is to migrate current databases to a single Information Technology (IT) platform that meets the agency's networking standards and will allow easier linkages in the future. This is planned for the Child Health Profile (CHP) database that includes three of the core datasets identified for HIP-Kids -- newborn hearing screening, newborn genetic/laboratory screening, and the Birth Defects Registry. These three databases will be linked with the birth records once they have been migrated to the new IT platform.

With continued collaboration, additional CHIERS modules will be developed and placed on the web for public access. A module from death records in CHIERS, maintained by vital records, is planned.

State Performance Measure 2: *Cumulative number of formal agreements, in the format of Memoranda of Agreements (MOA's) and collaborative agreements, that serve the needs of the three MCH populations.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					13
Annual Indicator				12	16
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2007	2008	2009	2010	2011
Annual Performance Objective	17	17	18	18	19

Notes - 2006

Data is from a survey of DPH programs including the CGMS database.

Notes - 2005

Data is from a survey of DPH programs including the CGMS database.

a. Last Year's Accomplishments

CT exceeded this objective. The DPH/FHS established MOAs with the Department of Social Services (DSS) to conduct the CT Healthy Start Program, a case management program for low-income pregnant women and their infants and children up to age 3, and a data sharing agreement, which allows the DPH to submit vital records data on an annual basis, which is linked to the Medicaid eligibility data at DSS.

The FHS established an MOA with the DMR for ensuring that infants identified with a hearing loss are referred and have accessed services provided by DMR (the Birth to Three System).

The FHS continues to have MOAs with University of Connecticut (UConn) for: (1) New Britain specific FIMR activities that will be ending this year; (2) Newborn genetic confirmation testing, treatment and follow up; (3) The CT Youth Health Service Corp (CYHSC). This positive youth development program has gained national recognition and the Area Health Education Center (AHEC) that administers the program has provided training on implementing the CYHSC to

several other states; and (4). The evaluation of the effectiveness of the Abstinence Only Program. The evaluation consists of developing and analyzing pre- and post-tests of program participants ages 9-13.

Staff updated and revised the Letter of Agreement that was developed between DPH/FHS and the New Haven Federal Healthy Start Program. The Title V Director met with the HS Program Director to discuss priorities and collaborative activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify collaborating partners at the state and local level				X
2. Inventory existing collaborations				X
3. Identify gaps in existing collaborations and opportunities for new partnerships				X
4. Monitor the effectiveness of collaborations and interventions				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The existing Abstinence Only MOA was amended to include development, piloting and analyzing of a curriculum for at risk youth who are in foster care; this activity was in collaboration with the State Department of Children and Families.

An MOA between DPH and UCONN was executed to develop a statewide surveillance system to identify the health related issues regarding fetal and infant mortality to understand what motivates and mobilizes communities to take action to prevent fetal and infant deaths. This statewide effort will identify the areas of greatest need and involve community collaborations, case ascertainment utilizing vital statistics and other data sources, record review, and possibly maternal interviews. An MOA was executed with Uconn for regional genetic services for infants who test positive through the state's newborn screening program.

The Title V Director met with the Program Director of the New Haven Federal Healthy Start Program to ensure that deliverables of the Letter of Agreement are being met and established new priorities/goals for FY 07.

Staff met with DSS CT Healthy Start Program Manager to negotiate new terms for the FY 07 MOA to provide case management services for pregnant women and to continue the existing MOA with DSS for the data sharing between departments.

c. Plan for the Coming Year

Identify at least one additional new partner to develop an MOA or formal agreement that serves the MCH population. DPH will assess the feasibility of developing an MOA with the Judicial Court System to formalize the collaboration with the Hartford Community Court in addressing adolescent paternity.

FHS Staff are working with the Department of Corrections (DOC) staff to develop an MOA to

implement a gender responsive curriculum for both DOC staff and inmates at York Correctional Institute (CT's only female prison).

DPH is collaborating with the Federal MCHB Healthy Start Program to roll out an Infant Mortality campaign targeting the African American community in June 2007. This was a collaborative goal identified in this year's letter of agreement and it is expected the the LOA will be renewed for the coming year.

An MOA with the Children's Trust Fund was executed for 1/1/07 to 6/30/08 to provide level II care coordination services for CYSHCN who do not have a medical home with a Title V Care Coordinator.

State Performance Measure 3: *Percent of 9-12 graders who reported being in a fight within the past 12 months.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					32.7
Annual Indicator				32.7	32.7
Numerator				715	715
Denominator				2185	2185
Is the Data Provisional or Final?				Provisional	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	32.6	32.6	32.5	32.5	32.4

Notes - 2006

This is weighted 2005 CSHS(formerly called YRBS) data. The survey is conducted every other year, so new data is not available this year, but anticipated for the following year's MCHBG reporting.

Notes - 2005

This is the weighted percent, with adjusted numerator from the unweighted frequencies of CT School Health Survey 2005. This survey is conducted every other year in conjunction with CDC's YRBS national surveys.

a. Last Year's Accomplishments

CT met its objective. The FHS continues to collaborate with other DPH staff managing the annual CT School Health Survey. We will monitor the trends related to the number of students who reported being in a physical fight in the past year with the completion of the 2006 CT School Health Survey.

According to DPH's "Adolescent Strategic Health Plan" (March 2005), specific strategies outlined in this plan related to this objective includes (1) The creation of opportunities for teen employment and workforce skill development; (2) Increase opportunities and venues where adolescents can learn and practice positive social-emotional skills; (3) Increase the number of schools that have peer mediation/conflict resolution and social development programs; (4) Improve availability and accessibility of education and support on violence prevention and non-violent behaviors for parents/guardians, families and caregivers of adolescents; (5) Support efforts to reduce availability of weapons; (6) Provide schools with resources to address violence in schools, such as support for peer mentoring programs, lesson plans addressing positive social-emotional skills and conflict resolution, and support for increased security on school grounds; (7) Reduce demand for drugs through substance abuse prevention and treatment strategies; and (8) Support efforts at the community level.

During the past year, 10 SBHC communities provided 310 Violence Prevention sessions to 1,188 students. There were additional sessions on Anger Management and Conflict Resolution. The FHS provided funding to the Area Health Education Center (AHEC) to implement another year of the Youth Health Service Corp. This positive youth development program engages high school youth in urban settings with an emphasis on providing them with exposure to careers in the health care field. High School students must complete the 9 module curricula and volunteer in a health care setting.

DPH partnered with AHEC to co-fund and implement the CT Youth Health Service Corp (CYHSC) with a purpose of promoting teen pregnancy prevention by engaging youth in activities that promote healthy behaviors and lifestyles and support workforce development by facilitating the transition of youth from school to employment in the health care field, particularly with underserved populations. A curriculum was developed that provided students with information on confidentiality/HIPPA, Homelessness 101, Ethical and Legal Issues and Applied Health Services. The program is now in its second year and has grown from two pilot school sites to approximately twenty schools sites in 11 cities/towns in Connecticut. The program currently has one hundred ninety-six students enrolled. The total volunteer placement hours are 838 and the total service learning project hours are 378.

In collaboration with the City of Hartford, the DPH hosts students from the Summer Youth Employment Program. Currently, the FHS has a high school student working in the Section for the summer.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Trends related to the number of students who reported being in a physical fight in the past year will be monitored with the completion of the 2006 CT School Health Survey			X	
2. Creation of opportunities for teen employment and workforce skill development				X
3. Increase opportunities and venues where adolescents can learn and practice positive social-emotional skills				X
4. Increase the number of schools that have peermediation/conflict resolution and social development programs				X
5. Improve availability and accessibility of education and support on violence prevention and non-violent behaviors for parents/guardians, families and caregivers of adolescents				X
6. Provide schools with resources to address violence in schools, such as support for peer mentoring programs, lesson plans addressing positive social-emotional skills and conflict resolution, and support for increased security on school grounds				X
7.				
8.				
9.				
10.				

b. Current Activities

The CT School Health Survey, a vehicle for obtaining information about students in grades 9-12 who report being involved in fights, is conducted every other year. A survey was not conducted in 2006. FHS is currently collaborating with other DPH staff responsible for the survey in preparation

for the 2007 edition.

Nearly all of the SBHC located in high schools statewide report an increase in physical fights in and outside of school. To address this trend, high school SBHC's are providing numerous services and activities that directly and/or indirectly impact aggressive behavior in the high school student (9-12 grades) population. Some SBHC high school sites are implementing nationally recognized programs including Positive Behavior Interventions and Supports (PBIS), a program geared toward preventing/reducing classroom discipline problems and Reconnecting Youth (RY), a school-based program for adolescents at risk for school dropout. One site is addressing bullying, violence and escalation of peer disputes through use of a Student Assistant Team approach that identifies students at risk and involves students, parents and teachers in creating a prevention plan. SBHC staff facilitates Gay Straight Alliance meetings, sponsors Violence Prevention week activities, supports immigrant awareness and participates in school and community based coalitions, taskforces and committees focused on reducing/preventing violence

c. Plan for the Coming Year

The 2007 CT School Health Survey will be utilized to track and update data for this measure.

At least one recommendation from the State Adolescent Health Plan will be implemented. SBHCs statewide will provide individual, family and group counseling to enrolled students and their families. Health education, promotion and risk reduction activities related to violence prevention will continue to be available to all students.

SBHC sites in the Bridgeport area will implement nationally recognized programs that include Positive Behavior Interventions and Supports (PBIS), a program geared toward preventing and responding to classroom discipline problems and Reconnecting Youth (RY), an indicated school based program for adolescents at risk for school dropout. Plans are being considered to continue implementation of Girl's Circle, a program for preventing girl violence.

Sites in high schools statewide will offer groups on topics including but not limited to: anger management, conflict resolution, social skills, friendship, healthy relationships and life skills to prevent/reduce school violence including fights.

State Performance Measure 4: *Percent increase in the number of adolescents 10-20 years old who receive services in school based health centers.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					4.2
Annual Indicator				3.1	10.2
Numerator				597	1986
Denominator				19439	19439
Is the Data Provisional or Final?				Provisional	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	15	20	25	30	35

Notes - 2006

Source: 2005-6 School-Based Health Center database, CT Dept of Public Health, Family Health Section. Baseline denominator for the start of this SPM represents the 2003-2004 number of students (19,439) receiving SBHC services. In School Year 2005-6 there were 21,425 students seen. These 1986 additional students seen represent a 10.2% increase over the base year.

Projections for the Annual Performance Indicator are based on an additional increase in the number of students receiving SBHC services each year expressed as a percentage increase over this original base year.

Notes - 2005

Baseline denominator is 2003-2004 number of students (19,439) receiving SBHC services. 2004-5 there were 20,046 students seen. These 597 additional students seen represent a 3.1% increase over the prior year. Projections for the Annual Performance Indicator are based on an additional increase in the number of students receiving SBHC services each year expressed as a percentage increase over this original base year.

a. Last Year's Accomplishments

CT exceeded its projection for this measure. For the 2006 reporting year, 10.2% of adolescents age 10-20 years old received services in school based health centers. Every SBHC site that served adolescents between the ages of 10-20 years old had at least one means of increasing enrollment and service utilization. Information about SBHC services was provided through dissemination of the new generic SBHC brochure and related publications, class presentations, school orientations, open houses, school newsletters, community newspapers, the DPH website and other mediums.

In-services were provided to school faculty, nurses, social workers, psychologists, guidance counselors, administrators and other related personnel. SBHC staff participated in regional and statewide initiatives that address: injury, obesity, asthma, teen pregnancy prevention, oral health and other adolescent orientated activities which provided opportunities to informally educate community based providers, community leaders and others about SBHC's and SBHC services.

The CT legislature appropriated a 3% general wage increase for all DPH funded SBHCs. This additional funding is was incorporated into contract budgets to provide for staff cost of living adjustments and maintain the levels of operation and services provided.

Opportunities for SBHC nurse practitioners and SBHC mental health clinicians to network and share resources were provided by DPH staff in the form of a mental health workgroup and nurse practitioner symposium.

DPH's Oral Health Program launched two pilot dental sealant programs in large, urban SBHC communities in the northern and southern regions of the state. This program expanded and enhanced the dental services provided at these targeted SBHC sites.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct outreach activities within and outside of the school setting		X		
2. Collaborate with school nurse and other school personnal to coordinate referrals and services		X		
3. Participate in community/regional/statewide initiatives				X
4. Recruit and retain SBHC staff				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Connecticut legislature appropriated an additional 9% in state funds that was added to SBHC contracts for staff cost of living adjustments and to maintain current hours of operation and service levels. The CT State Legislature allocated funds to implement expanded school health programs that include mental health and dental services to eight elementary schools in one new community, increasing the number of access points into care for students with limited resources and/or no insurance.

DPH staff participates in activities related to the SAMSHA Mental Health Transformation Grant as co-convenor of the Early Mental Health Prevention, Screening, Assessment and Referral to Services are Common Practice Workgroup which focuses on developing and implementing strategies to increase access to mental health services for adolescents and other populations across the lifespan.

The data consultant supported by HRSA Technical Assistance funding completed her assessment of the data collection and management system currently employed by the SBHCs. Staff are conducting trainings on utilization of the data collection and management system currently in use and revising the user manual are the workgroup's are the current focus of the workgroup participants. This TA will assist with better tracking of SBHC utilization.

c. Plan for the Coming Year

At least one recommendation from the adolescent strategic health plan will be implemented.

Activities for next year include SBHC outreach activities at the state and community level through continued dissemination of the new SBHC brochure, the DPH website, participation in health fairs, attendance at conferences, increased collaborations with other state agency staff and community based providers that have yet to partner with DPH around matters related to adolescents and school based health centers.

The data workgroup will continue implementing the recommendations of the data consultant.

DPH staff will serve as co-convenor of the Early Mental Health Prevention, Screening, Assessment and Referral to Services are Common Practice Workgroup as part of the Mental Health Transformation grant.

The dental sealant pilot programs will be continued in designated communities, and will provide reports back to SBHCs based on the data they submit to DPH.

One million dollars in State bonding funds have been allocated for the expansion of SBHC in CT. Staff will be developing the RFP for the allocation of these funds. It is expected that additional students will be served as a result of this expansion.

State Performance Measure 5: *Percent of schools that have used a program to reduce obesity through physical exercise and nutrition education programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					6.5
Annual Indicator					
Numerator					

Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	7	7.5	8	8.5	8

Notes - 2006

State Dept of Education (SDE) completed their first School Nutrition and Physical Activity Practices (SNPAP) survey in the Spring 2006. Therefore, there is no 2005 baseline data. We have projected a conservative 0.5% increase annually among the approximately 1000 public schools in the state that will implement school policies that promote healthy lifestyles to a degree which meets the acceptable level.

Notes - 2005

State Dept of Education (SDE) completed their first School Nutrition and Physical Activity Practices (SNPAP) survey in the Spring 2006. Therefore, there is no 2005 baseline data. We have projected a conservative 0.5% increase annually among the approximately 1000 public schools in the state that will implement school policies that promote healthy lifestyles to a degree which meets the acceptable level.

a. Last Year's Accomplishments

With the development of the Connecticut DPH Healthy Eating and Active Living Plan, press coverage unveiled the program to the public in November 2005. This activity helped spur a legislative bill that signed by the Governor on May 19, 2006 (Public Act 06-63). The legislation restricts the sale of unhealthy beverages, allowing milk, 100% fruit juices, vegetable juices, and water beverages in public schools. The bill also mandates that these schools meet state standards for healthy foods provided in the schools.

In addition to the above legislation, Section 204 of the Child Nutrition and WIC Reauthorization Act of 2004 requires schools that participate in the USDA child nutrition programs to establish a school wellness policy. Among its required components are: 1) goals for nutrition education, physical activity to promote student wellness; 2) nutrition guidelines for all food available at school; and 3) a plan for measuring implementation of the wellness policy. Benchmarks for implementation are not specific.

The State Department of Education developed and initiated an annual school survey in Spring, 2006 to monitor progress of all public schools as they implement their policies in four categories. Called the School Nutrition and Physical Activity Practices Survey, the survey evaluates progress in nutrition education, school food practices, physical education and physical activity, and communication and promotion. The survey also evaluates progress toward the Coordinated School Health model and identifies barriers to improved nutrition and physical activity within the schools. Last year, the survey was sent to 1,050 school principals in early May 2006, and 294 responded (a 28% response rate).

The Family Health Section of DPH, in partnership with the DPH Obesity Program and state Department of Education, developed a composite score from the School Nutrition and Physical Activity Practices Survey to annually monitor implementation of individual school policies that promote healthy eating and physical activity. The score described the degree to which policies related to nutrition education, school food practices, physical education and physical activity, and community and promotion, were implemented within each school. The scores for all responding public schools across the state were then used to determine the State Performance Measure for this objective.

Of the public school principals within Connecticut who responded to the School Nutrition and Physical Activity Practices Survey, 6.5% indicated a degree of implantation that was at least 75%.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support allocation of \$500,000 state funds to develop fitness programs and nutrition programs for overweight children				X
2. Promote partnership with newly created Obesity Program within DPH				X
3. Promote partnership with state Department of Education				X
4. Support partnerships with school-based health centers and community health centers				X
5. Support survey through Department of Education to monitor school policies across the state				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Staff partner with the SDE to ensure that the School Nutrition and Physical Activity Practices Survey is conducted in the spring of each year. Conducted in partnership with the Rudd Center for Obesity at Yale University, the results of the second annual survey were used to develop the State Performance Measure, and to monitor implementation of school policies that promote healthy lifestyles and barriers to implementation. Data are not yet available.

The Obesity Program participates on the Connecticut Childhood Obesity Council, which has identified accurate, up-to-date childhood obesity data as a priority for the state's children. Work will continue on this important topic in the coming year. The ConnectiFIT Worksite Wellness Program, the Healthy States Grants program, the Connecticut Partnership for Healthy Schools, and the Governor's Committee on Physical Fitness are also addressing issues of obesity in the state, and the Obesity program within DPH participates in these groups.

During the previous fiscal year, state legislation was passed to restrict beverages available in schools to healthier alternatives (PA 06-63). This year, the state legislature, in its two-year budget, proposes to allocate \$500,000 in state funds to develop physical fitness and nutrition programs for children who are overweight or at risk of becoming overweight (File Number 07-679). The state budget has not yet been approved.

c. Plan for the Coming Year

The Obesity Program within the DPH will participate on the Connecticut Childhood Obesity Council, which has identified accurate, up-to-date childhood obesity data as a priority for the state's children. Work will continue on this important topic in the coming year. The ConnectiFIT Worksite Wellness Program, the Healthy States Grants program, the Connecticut Partnership for Healthy Schools, and the Governor's Committee on Physical Fitness are also addressing issues of obesity in the state, and the Obesity program within DPH participates in these groups.

In addition to these regular activities, the Obesity Program plans to produce an addendum to the State's Obesity Plan that will address childhood obesity and disparities related to obesity. The Program also plans to develop statewide capacity to promote worksite wellness programs.

Family Health Section staff will continue to broaden partnerships with school-based health centers to promote healthy eating and active living among the students, complement new school

policies in nutrition and activity, and encourage and facilitate implementation of these policies. Staff will also continue to nurture partnerships with the state Department of Education and the DPH Obesity Program, and will continue to encourage legislative action that addresses obesity.

The Community Health Center, Inc, New Britain was recently awarded funding from the MCHB's Healthy Tomorrow Partnership for Children Program. FHS staff will participate on the implementation committee. The five-year grant, called "Food Smart and Fit" will build skills and knowledge to empower high-risk girls in grades 9-12 to be peer leaders.

State Performance Measure 6: *Percent of infants born to women under 20 years of age receiving prenatal care in the first trimester*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					70.5
Annual Indicator				69.8	70.4
Numerator				2004	1984
Denominator				2870	2820
Is the Data Provisional or Final?				Final	Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	70.5	70.7	70.9	71.1	71.3

Notes - 2006

Source: CTDPH Vital Statistics CY2005 provisional data. A marked difference is observed between the White Non-Hispanic early prenatal care experience of 76.5 percent compared with White Hispanic infants at 68.1%.

Notes - 2005

Data is from DPH Vital Statistics, Calendar Year 2004.

7/07 Note: Final CY2004 data just run has resulted in changes to this measure reflected here.

a. Last Year's Accomplishments

In 2004, of the 2,834 women under age 20 giving birth, 1,992, or 70.3% received prenatal care in the first trimester. White non-Hispanic teens (75.8%) were most likely to receive early prenatal care, followed by Hispanic teens (68.9%) and Black teens (65.9%). Data from other race categories were too small to report. Connecticut met its objective for the related national performance measure #18 by assuring 88.9% of pregnant women of any age received prenatal care in the first trimester. This is an improvement from last year, during which CT achieved 85.6%. In the coming years, CT hopes to see this positive trend with the under 20 years of age population.

The Pregnancy Risk Assessment and Tracking System (PRATS) survey is an 88-question survey designed to identify risk factors associated with adverse pregnancy and birth outcomes. The second round of the survey, conducted in 2003, was mailed to 4500 [recent] postpartum women in CT. The response rate (44.2%) was lower than desired, and results could not be generalized beyond the survey respondents. However, survey findings were consistent with DPH Vital Statistics data. Women under 20 were less likely to enter prenatal care (PNC) in the first trimester (83.7%) compared to other age groups, and were less likely to have received PNC as early as desired. Whereas race/ethnic disparities were seen in the receipt of early PNC among the respondents, overall, after adjusting for maternal age (i.e., women <20), there was no statistical difference [by race/ethnicity]. Hispanic teens (84.0%) were most likely to report early entry into PNC, followed by Black, non-Hispanics (82.4), and White, non-Hispanics (80.0). A report of the

findings from Round 2 of PRATS was released this year, and made available to interested parties via the DPH website.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and intensive case management to identify and enroll clients in early prenatal care		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services and providers	X			
3. Provide outreach to targeted populations (i.e. pregnant substance users)		X		
4. Provide support, information and advocacy to pregnant teens	X			
5. Provide pregnancy testing, reproductive health education, counseling and prenatal linkage to community based providers	X			
6. Promote early enrollment into prenatal care as a linkage from programs such as WIC		X		
7. Provide and promote comprehensive services to encourage women of reproductive age to enter prenatal care early		X		
8.				
9.				
10.				

b. Current Activities

Title V funded case management programs for pregnant women (Comadrona, HCWC, Healthy Start and RFTS) provides outreach and intensive case management to pregnant women in the first trimester. Through its community-based networks, clients are identified and referred to prenatal care providers. Healthy Choices for Women and Children provides outreach and intensive case management to pregnant women who by virtue of a history of substance use may encounter barriers in obtaining early prenatal care. The program educates clients on the benefits of early pregnancy care.

Results from Round 2 of the CT PRATS survey were presented to DPH staff, external partners, and stakeholders. Due to several limitations of the data from Rounds 1 and 2 of PRATS, data have been used to compliment existing data; further analytic analyses were not pursued. Rather, additional analyses of the data have begun that will inform Round 3 of the survey, which is currently planned to begin in 2009.

In collaboration with the Federal New Haven Healthy Start, DPH will launch a campaign addressing infant mortality in the African American population. The campaign will include the message of the importance of seeking early prenatal care services via television, radio, and posters.

WIC emphasizes and promotes early enrollment into their program and provides screening and referral to prenatal care providers. The program continually focuses on 1st trimester enrollment to low-income pregnant women.

c. Plan for the Coming Year

Epidemiology Unit staff will continue preparations for Round 3 of the CT PRATS survey. This work will include refining the sampling plan based upon analyses of respondents versus non-respondents from the previous 2 surveys; identifying an appropriate birth cohort and drawing the sample; finalizing survey content; and releasing an RFP to identify a contractor to administer the survey. Data from Round 3 will be used to identify and further investigate important factors related to seeking and accessing early prenatal care.

Family Planning will provide reproductive health care to outreach and refer pregnant women to community-based programs to promote early prenatal care.

The Fetal and Infant Mortality Review has been transitioned to a statewide system and full statewide implementation is expected to begin July 2007. DPH is collaborating with the University of Connecticut to conduct the statewide surveillance program. Staff will work with Uconn to review the analysis of the statewide FIMS data and to disseminate the data to local communities.

Staff will participate on the Hartford Health Department's MCH Advisory Team to provide guidance and support for HHD's City Match/CDC Technical Assistance grant for addressing preconception care in Hartford. An Action Plan will be developed and a Summit is being planned for early December.

Funding will be sought to continue and expand the IM campaign which promotes early entry into care.

As of January 2008, a new program for case management services for pregnant women and teens will be rolled out (previously RFTS and Comadrone). This program will focus on early entry into prenatal care and interconceptional care.

State Performance Measure 7: *Percent of CYSHCN who receive family-centered, community-based, culturally-competent, comprehensive, coordinated family/caregiver support svcs incl. respite in the Regional Medical Home System of Care*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					26.4
Annual Indicator					44.9
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional
	2007	2008	2009	2010	2011
Annual Performance Objective	54.1	57.3	60.8	64.4	67.8

Notes - 2006

The baseline data starting in FY2006 reflects the first year of the new methodology and contracts with the regional medical homes. Projected years after FY2006 reflect the contract requirements of these five centers.

Notes - 2005

The baseline data starting in FY2006 reflects the first year of the new methodology and contracts with the regional medical homes. Projected years after FY2006 reflect the contract requirements of these five centers.

a. Last Year's Accomplishments

Data for FFY 2006 reflects a change in methodology. The denominator for this State Performance Measure has changed to reflect the RMHSC contract changes, which include the expansion from two to five Centers and the requirement for all Centers to serve a greater number of CYSHCN than had been required previously. The RMHSC will utilize the Docsite Care Coordination sheet to document activities.

The Regional Medical Home Support Center (RMHSC) System of Care for CYSHCN provided family/caregiver support services that covered a full range of needs including medical, educational, and community supports and then completing the circle of sharing by linking information through the families medical home. Each RMHSC had specific responsibilities related to supporting medical homes by providing family-centered, community-based, culturally competent, comprehensive, and coordinated family/caregiver support services including respite to children and youth with special health care needs.

The RMHSC focused activities on a previous statewide study of families of children and youth with special health care needs which identified the top five barriers to care as; lack of information about services, lack of people to help get services, too much paperwork to get services, paying for care, and lack of legal assistance. The same study identified the top five services needed and not received included the following; respite services both planned and emergency, summer camp both days as well as overnight, and after school programs.

Authorization protocols for the distribution of direct and camp respite funds were expanded to include the Respite Child and Family Need Checklist. The RMHSC's utilize the Checklist along with information gathered during assessment to help decided how to distribute the respite funds between direct respite funding of up to five hundred dollars per child for a year and camp scholarships.

Three of the RMHSC's hosted respite family forums based on the DPH "Get Creative About Respite" manual. The forums, for both families and community providers, reviewed the Parent and Child/Adolescents sections of the manual and allowed for the sharing of local community support solutions. The forums were well attended and the RMHSC received positive feedback from participants. One of the RMHSC's continued to offer the respite family forum monthly.

DPH provided a letter of support to the Connecticut Lifespan Respite Coalition in their efforts to secure funding to further expand the distribution of the "Get Creative About Respite" manual through collaboration with the RMHSC's and the families and providers they support.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family-centered, community-based, culturally competent, comprehensive, and coordinated family/caregiver support services		X		
2. Coordinate statewide access to support services through Child Development Infoline				X
3. Capture and document care coordination activities		X		
4. Distribute "Get Creative About Respite" and "Directions" manuals, direct and camp respite funds	X			
5. Provide forums for sharing of "Get Creative About Respite" manual and other community support solutions		X		
6. Work with state agencies, community providers, and families to further expand the sharing of community support solutions				X
7.				

8.				
9.				
10.				

b. Current Activities

Data for FFY 2007 reflects a change from the Docsite database to an Access database. The Regional Medical Home Support Center (RMHSC) System of Care for CYSHCN provides family/caregiver support services that cover a full range of needs including medical, educational, and community supports and then completing the circle of sharing by linking information through the families medical home. RMHSC's continued to distribute direct and camp respite funds to Connecticut children and youth with special health care needs.

DPH distribute the Get Creative About Respite manual and began the process to identify funding for additional copies of the manual. DPH staff edited, printed and disseminated Directions: Resources for Your Child's Care, an information organizer for families, available both in hard copy and electronically (through the DPH web site).

National Lifespan Respite Care Act of 2006, public law 109-442 authorized competitive grants to Aging and Disability Resource Centers in collaboration with a public or private non-profit state respite coalition or organization to make quality respite available and accessible to family caregivers regardless of age or disability. Connecticut proposed legislation that identifies the Department of Social Services as the agency to contract with nonprofit organizations that promote the purposes set forth in the Lifespan Respite Care Act of 2006.

c. Plan for the Coming Year

DPH contractors will support the newly established medical homes in providing family-centered, community-based, culturally competent, comprehensive, and coordinated family/caregiver support services including respite to children and youth with special health care needs. The contractors will continue to capture data related to care coordination activities covering a full range of needs including medical, educational, and community supports.

CLRC has been selected to administer the DPH respite and extended services funds for CYSHN. This includes the processing of requests for respite care provided in or out of the home for the purpose of providing relief to the family/caregiver from the daily responsibilities of care provision for a child or youth with special health care needs. These services will be family-directed with provider and location of the respite services of the family's choice. The contractor's will work with state agencies, community providers, the Connecticut Lifespan Respite Coalition, and families statewide to further distribute the "Get Creative About Respite" and "Directions" manuals and provide forums to share local community support solutions.

CHDI has been selected as the contractor to help grow and enhance the family-centered Medical Home concept in Connecticut by providing statewide outreach and culturally competent education to pediatric primary care providers and families on the concept of medical home for children and youth with special health care needs, and, link these children to medical homes when available and family support services.

Family support services, a component of the CHDI activities, will include providing assistance and culturally appropriate education to families of CYSHCN that will enable families to acquire the skills necessary to access needed medical and related support services, families will learn to link to needed supports, which in turn will help to empower families to become competent supporters for their children.

The format of the Medical Home Advisory Council meetings will be restructured so that families who participate on the MHAC are provided the opportunity to include family driven issues on the

agenda.

State Performance Measure 8: *Percent of licensed child care centers serving children age birth to five who have on-site health consultation, as defined by the standards in "Caring for Our Children".*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					0
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2007	2008	2009	2010	2011
Annual Performance Objective	0	0	0	0	0

Notes - 2006

This SPM is now labeled developmental as CT is working to implement methodology to collect data to measure the percent of day care centers who have on-site health consultation by an appropriately qualified health professional.

Notes - 2005

This SPM is now labeled developmental as CT is working to implement methodology to collect data to measure the percent of day care centers who have on-site health consultation by an appropriately qualified health professional.

a. Last Year's Accomplishments

In November and December 2005, Region I conference calls included updates from states on their Early Childhood Comprehensive Systems (ECCS) plans. One recommendation was made that Region I states should look for opportunities to collaborate on similar issues/recommendations or themes from their ECCS plans. In the January conference call, more discussion lead to an interest in Early Childhood issues especially in relation to a strengths-based measure, and as the possible common state performance measure. By mid-February, the early childhood idea was becoming more focused to look at early literacy or health consultation in child health care environments. States requested more definitive language regarding this measure that was distributed prior to the AMCHP meeting in March. At the annual AMCHP meeting in March, Region I states were asked to determine whether they would include an early childhood measure with a focus on health care consultation in their MCHBG applications. By the March Region I conference call, Connecticut, Massachusetts, Maine and Vermont were committed to incorporating this measure into their MCHBG applications. New Hampshire expressed that they had no established data source or statewide network for child care health consultants.

In Connecticut, we met with our Day Care Licensing Section to learn how their licensing and regulatory inspections occur and how we could utilize the information they collect to help with this measure. We learned that CT DPH's Day Care Licensing Section conducts site visits of "Child Day Care Centers" as defined per CT regulation every other year. The inspection documents whether the day care center has the required health consultation log indicating that a Child Care Health Consultant has provided services to that center. We discovered that DPH's Radon Program was also interested to obtain information from the inspection form and had begun a process to obtain copies of all the inspection forms to manually extract the information they wanted and put into a simple Excel spreadsheet. Since we do not have a mechanism in place yet to obtain the data needed for this measure, we have no baseline data or projections on the SPM#08 detail sheet. DPH staff managing the Early Childhood Partners (ECP) grant, discussed

the formation of this measure with representatives from the CT Nurses Association (CNA). The DPH contracts with the CNA to provide trainings and activities to sustain the CCHC (child care health consultant) system in the state.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Meet with the Radon Program to review the collected Day Care Licensing inspection forms				X
2. Enter forms into an Excel spreadsheet with the assistance of the Radon Program				X
3. Review data looking to identify Child Day Care Centers that were non-compliant on the inspection forms on maintaining a health consultation log				X
4. Establish baseline on the compliance of maintaining the health consultation log at Child Day Care Centers for future comparison				X
5. Participate on the monthly Region 1 conference calls to continue the dialogue regarding the progress of other Region 1 states in meeting this measure				X
6. Discuss progress towards meeting this measure at the CT Early Childhood Partners quarterly steering committee meeting, to seek additional input from steering committee members				X
7.				
8.				
9.				
10.				

b. Current Activities

FHS staff met with Day Care Licensing staff to discuss the actual available data from the CT Day Care Health Consultant database. In light of the fact that the database was not able to report whether a center had been visited at least once a month by a licensed health care consultant, we updated the language to reflect information that can be obtained from the database with the resulting new SPM language: "The percent of licensed child day care centers serving preschool age children that have reported having contracts with the required four consultants (health, dental, educational and social service) to conduct the required site visits, and to ensure that the health, dental and social service consultants' licenses are current."

DPH plans to meet with the Radon Program to develop a mechanism to extract the needed information from the inspection forms necessary for the Radon Program as well as for this SPM.

The Title V Director, or her designee participates on the monthly Region 1 conference calls to continue the dialogue regarding the progress of other Region 1 states in meeting this measure. The progress towards meeting this measure, and the accompanying activities will be discussed with the DPH Early Childhood Partners staff to seek additional input.

FHS clerical support assists the Day Care Licensing Program with the data entry of the health consultation information into the database on a periodic basis to assure the availability of information for this performance measure.

c. Plan for the Coming Year

FHS clerical support staff will continue to assist the Day Care Licensing Program with the data entry of the health consultation information into the database on a periodic basis to assure the availability of information for this performance measure. Once the data is at a point where queries can be completed, FHS staff will work with IT staff to obtain the baseline data from this database.

DPH staff will meet with the Day Care Licensing Section to check on their progress toward computerizing the inspection forms and seek ways to support this project.

FHS will continue to partner with other Region One states and participate in conference calls as it pertains to the SPM.

E. Health Status Indicators

The Connecticut Department of Public Health (DPH) continues to utilize the health status indicators as one source of data to look at trends as it relates to MCH indicators. Further analysis of the data would be required to reach definitive conclusions. However, the HSIs, along with other MCH data, help to paint a more complete picture of the health status of the MCH population in CT.

Specific program evaluation data should be more carefully reviewed, to identify consistency with the HSI data. For example, HSI #1 reveals a decrease in the rate of children hospitalized for asthma. The DPH needs to compare the activities of the Asthma Program and its impact on this indicator.

The DPH will need to partner with other agencies, in particular the Department of Social Services to fully understand the impact of the additional \$1,000,000 state funds allocated for HUSKY outreach to increase enrollment. Positive trends are noted in HSIs #03, 07A, and 07B.

HSI # 04 appears to be a downward trend and the DPH is currently working to address racial and ethnic disparities as they relate to access to prenatal care and birth outcomes. In collaboration with the Federal New Haven Healthy Start Program, messages are being aired that include encouraging women who are pregnant to seek early and continuous prenatal care. Further analysis would be required to determine whether there are significant numbers of women based on age, race, health insurance or other factors.

As the DPH transitions to a community based model for the medical home program, it is expected that HSI #08 would turn in a more positive direction.

In summary, the data presented in the HSIs needs to be further analyzed and translated into programmatic activities. It also needs to be analyzed in combination with other datasets (PRATS, etc) to ensure that a more comprehensive view is obtained. The DPH will continue to partner with other state agencies and community based organizations to address the HSIs. The HSIs certainly provide a foundation for analysis with the upcoming five-year MCH needs assessment.

F. Other Program Activities

Many other programs within DPH affect the MCH population but are not funded through MCHBG. Some of these are listed below:

The Abstinence-Only Education Initiative supports a community-based abstinence-only education program in Bridgeport CT, to promote abstinence from sexual activity among racially and ethnically diverse, nine- to 14-year-old males and females.

/2008/ Connecticut no longer receives funding for Abstinence Only programs./2008/

The asthma program's mission is to reduce asthma-associated morbidity and mortality and improve the quality of life for people with asthma. The asthma program and FHS staff has collaborated to assess Title V program data and activities to develop interventions for children diagnosed with asthma.

/2008/ The Asthma Program's mission is to reduce asthma-associated morbidity and mortality and improve the quality of life for people with asthma. The Program collaborated with the FHS staff to assess Title V data for children with a diagnosis of asthma and develop a baseline that can be used to evaluate effectiveness of future interventions./2008/

Breast and Cervical Cancer Early Detection Program provides screening and diagnostic services through 18 primary health care facilities and over 100 subcontractors throughout the state. The program provides case management and community-based education and outreach targeting medically underserved women.

Childhood Lead Poisoning Prevention Program operates a comprehensive lead surveillance system, provides professional and community education services and operates 2 regional lead treatment centers. The DPH laboratory provides blood lead testing.

/2008/ Has been renamed the Childhood Lead Poisoning Prevention and Control Program and lead poisoning prevention activities are now centralized in the Regulatory Services Branch./2008/

Chlamydia Infertility Prevention provide free chlamydia screening and treatment services to females and their partners who attend targeted Planned Parenthood clinics.

/2008/ Free services are available at clinics to under and uninsured females, particularly those under 25 and sexually active, and their partners./2008/

Comprehensive STD Prevention Systems Projects provides services to reduce the transmission and incidence of STDs including surveillance to monitor the trends facilitating individual case intervention.

Enhanced Perinatal HIV Surveillance receives CDC funding to conduct surveillance. All perinatal HIV exposures (approximately 75 infants per year) are followed-up with medical record reviews to collect information about maternal HIV testing, prenatal care, risk factors, treatment compliance, etc.

"Five-a-Day" Head Start Project focuses on providing direct nutrition education to Food Stamp eligible families in CT with the "Captain 5-A-Day" program for children and the "Supermarket Smarts" program for parents and families. These programs are delivered through workshops by state nutrition staff and provide education on food budgeting and developmentally appropriate feeding practices, and encourage dietary behavior modification including the purchase and consumption of fruits, vegetables and other low-fat foods.

Healthy Child Care CT more than 50 organizations that play a key role in the planning and delivery of child care and health care for children and families. Leadership is provided by a collaborative effort of DPH, DSS, and the Children's Health Council through the CT Head Start State Collaboration Office. /2007/ This program will be reported with the Early Childhood Program./2007/

Immunization Program activities are designed to prevent disease, disability and death from

vaccine-preventable diseases in infants, children and adults. The Immunization Action Program funds 11 full time health departments, 2 health districts, and 4 additional community providers to conduct activities to raise immunization rates and the Vaccines for Children provides free vaccines to over 500 health care providers to eliminate cost as a barrier to receiving immunizations. Also, The CT Immunization Registry and Tracking System permanently records and tracks all CT children's immunizations given in childhood.

Intimate Partner Violence prevention is currently addressed at hospitals statewide by providing training to health, mental health and public health professionals, paraprofessionals and students statewide regarding intimate partner violence issues, screening and appropriate referral. Efforts are underway to address intimate partner violence with the women's correctional institute (York Correctional Institute).

Perinatal Hepatitis B Prevention: All hepatitis B positive pregnant women and their providers are contacted to provide education about the implications of hepatitis B infection in pregnancy, offer testing and vaccination to family members and ensure that the infant receives appropriate immunization and testing.

/2007/ Primary Care Services Resource Coordination and Development Grant activities coordinate local, state, and federal resources that contribute to primary care service delivery and workforce issues in the state to meet the needs of CT's vulnerable and high risk populations.//2007//

Ryan White Care Act provides federal support for comprehensive health and social services for people living with AIDS and HIV disease, including women, infants and children. There are many AIDS activities aimed to serve women, infants, and adolescents.

Sexual Assault Prevention and Intervention Services ensures the provision of direct services for victims of rape and other sexual assaults throughout the state. DPH contracts with the CT Sexual Assault Crisis Services, Inc., an umbrella agency, to coordinate these efforts.

/2008/ Staff will be convening a committee to develop a statewide sexual assault prevention strategic plan.//2008//

WIC serves approximately 55,000 participants in CT. They include low income pregnant, breastfeeding and postpartum, non-breastfeeding women, as well as infants and children up to five (5) years.

WISEWOMAN (The Well-Integrated Screening and Evaluation for Women Across the Nation Program) incorporates cardiovascular disease screening and intervention services into the healthcare delivery system at nine contracted health care provider sites.

G. Technical Assistance

The Connecticut DPH has been fortunate to have access to the MCHB's Technical Assistance Program. Access to this TA has provided the DPH with expert consultants that have helped to build the state's MCH infrastructure without depleting our existing resources. During 2006-7, the DPH conducted four major activities using the TA program. The first was to support a 2-day visit for Patti Hackett, MD, Co-Director, Healthy and Ready To Work National Resource Center and Patience White, MD, FAAP, MA Medical Home and Transition Medical Advisor, HRTW, and Chief Public Health Office at the National Arthritis Foundation. During the 2-day visit, separate meetings were convened with our Medical Home Advisory Council, new Medical Home contractors, State Department of Education staff and an evening meeting with representatives from the CT Chapter of AAP and Kids As Self Advocates (KASA). This activity related to NPM #6.

The Second TA conducted this year, was expert consultant by Glynis Shea. Ms. Shea is from the Konopka Institute and conducted an evening and morning session on improving adolescent health through communications as outlined in the DPH's State Adolescent Health Strategic Plan. This TA brought together a diverse group of stakeholders and provided them with practical skills to build public will for youth and shape communication strategies. This activity relates not only to SPM # 4 but to all other measures that address adolescent health.

The third TA was for expert consultation for assisting the DPH in developing a State Sickle Cell Plan. In collaboration with the Hospital for Special Care, who was the recipient of a HRSA grant, the DPH worked with Marijane Carey of Carey Consultants to develop the state plan. The plan included input from families with sickle cell disease/trait, as well as community based organizations and state agencies.

The fourth TA request is for expert consultation of assisting the DPH's collaboration with the Hartford Health Department in addressing preconception health care in the City. The HHD received a TA grant from CDC/CityMatCH and the Title V Director has been actively involved in the grant activities. Expert TA was needed to help develop an Action Plan to better address preconception care in Hartford with the expectation that the results can be shared and replicated in other cities in the state.

There are currently two TA request approved but not yet utilized. In collaboration with other Region One states, DPH will participate in a Region One MCH meeting in October. The other request is for expert consultation from Dr. Richard Wasserman and Judith Shaw of VT to present the VCHIP program for possible replication in CT.

For FFY 2007- 8, TA requests focus on the following areas: the integration of violence prevention into Title V community based programs (NPMs #16,18 and SPM #3), expert consultation for SBHCs to better utilize their data system for more complete and accurate reporting on utilization as well as a consultant to provide expertise regarding the expansion of the SBHC system. The final request is for expert consultation to work with DPH staff to better integrate the needs of teen fathers in MCH programs.

V. Budget Narrative

A. Expenditures

There were many overall factors that impacted the actual expenditures in comparison to the FFY2005 budget. More details specific to each of the Budget Forms are described below.

Form 3

For FFY2005, not all of the Federal Allocation was spent for several reasons, including professional staff moving to other positions, a delay in payment for contracted services, and a delay in filling other Title V funded vacancies.

Other sources of Federal funds were not fully expended in FFY2005. The Abstinence Education grant award period does not end until September 30, 2006, so funds have not yet been fully expended. Newborn Hearing Screening funds were not fully expended because of a delay in payment for contracted services within the FFY2005 period.

Form 4

A review of program activities resulted in a shift of the apportionment of funding among the population groups served with the MCHBG funding and the Maintenance of Effort/State Match funding. Similarly, the reapportionment of staff time to different population groups as well as a shift in the selection of State programs used to comprise the State Match account for differences in amount expended.

FFY2005 marked a change in services to CYSHCN. This was a transition year for CT, in that the use of two CYSHCN centers as the system of care was shifted to five Regional Medical Home Support Centers. The funds budgeted to this population group were not fully expended due to this transition.

The amount expended for "Other Populations" exceeded the budgeted amount due to activities funded for male/father involvement through the New Haven Family Alliance Male Involvement Network. Also, Title V funds helped promote a website through the CT State Library to target parents and care-givers of children age 0 - 8 years. The amount expended for Administrative costs in FFY 2005 exceeded the planned amount due to funds provided for storage and dissemination of MCH materials, and funding MCH related training.

Form 5

Among the contracts and programs supported through the MOE and Title V funds, there was a shift in the way of accounting for these services among the levels of the service pyramid. The addition of several new staff in FHS accounts for the difference in amount expended in population-based services and enabling services.

The difference in amount expended for Enabling Services was also due to a delay in filling vacant staff positions in the Oral Health Unit during FFY2005. And also contributing to the difference in amount expended for Population-Based Services was a decrease in spending for SIDS/Bereavement services.

B. Budget

State matching funds are met through funding of School-Based Health Centers, The Genetics Diseases Program, and the CYSHCN/RMHSC Clinics. These matching funds will total \$3,968,000 for FFY 2007. For FFY 2007, the maintenance of effort requirement is met from several sources: Community Health Centers, Family Planning Programs, and the School-Based Health Centers located throughout the state. The State of Connecticut dollars for these programs total \$7,095,000 for FFY 2007 (maintenance of effort total includes the matching).

Other state-funded programs that serve the maternal and child health population include: Community Health Centers, Lead Poisoning Prevention, Asthma, Genetic Sickle Cell Program, Healthy Choices for Women and Children, Expanded School Health Services, Rape Crisis and Prevention Services, Oral Health, Pregnancy Related Mortality Surveillance, Fetal and Infant Mortality Review, Youth Risk Behavior Surveillance, and Family Planning. In addition to these programs, there are several state-funded DPH personnel who provide support to the maternal and child health programs.

The requirement that there be three dollars of State matching funds for each four dollars in federal funding is met for FFY 2007. The federal allocation for FFY 2007 is \$ 4,803,010 which means that the State of Connecticut must match with at least \$3,602,257. Three dollars and thirty-one cents (\$3,970,000) is funded for each four dollars in federal funds awarded. Maintenance of Effort for FFY 2007 is in the amount of \$7,095,000, which is \$317,809 more than the required FFY 89 base of \$6,777,191.

Other federal grants received by the Family Health Section that serve the maternal and child population will include: Rape Crisis and Prevention, Intimate Partner Violence, Universal Newborn Hearing Screening, State Systems Development Initiative (SSDI), and ECP, CT's CECCS program.

The allocation plan requires that 30% of the FFY allocation be budgeted for Prevention and Primary Care services, as well as 30% for Children with Special Health Care Needs. For the FFY2007 award amount, \$1,443,476 (30.05%) is allocated for Preventive and Primary Care for Children; and \$1,605,278 (33.42%) for the CSHCN program. There is an allocation of administrative costs of \$174,432 (3.63%) of the projected federal allocation to all programs.

In FFY 2007, the federal allocation is \$4,803,010 plus using \$627,488 of the carry forward from FFY 2005 funds for a total of \$5,430,498 of federal funding. When combined with the state funds of \$7,095,000 there is a federal-state block grant partnership total of \$12,525,498.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.